MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING
(PUBLIC AGENDA)

TO BE HELD ON MONDAY 10TH JULY 2023
At 2:00pm

Main Boardroom
Cobbett House

A G E N D A

1.	Apologies for absence	
2.	Declarations of Interest	
3.	To approve the minutes of the Board of Directors' meeting held on 9th May 2023	*(enclosed)*
4.	Patient Story	*(Film)*
5.	Matters Arising	
6.	Chairman's Report	*(Verbal Report of the Group Chairman)*
7.	Chief Executive's Report	*(Report of the Group Chief Executive enclosed)*
8.	Reports from the Board of Directors' Scrutiny Committees • EPR Scrutiny Committee held on 26th April 2023 • Audit Committee held on 20th June 2023 • Quality and Performance Scrutiny Committee held on 20th June 2023 • Workforce Scrutiny Committee held on 20th June 2023 • Finance and Digital Scrutiny Committee held on 27th June 2023	*(Reports of the Group Non-Executive Directors enclosed)*
9.	**Operational Performance**	
	9.1 To receive the Integrated Performance Report	*(Report of the Group Executive Directors enclosed)*
	9.2 To receive the Group Chief Finance Officer's Report	*(Report of the Group Chief Finance Officer enclosed)*
	9.3 To provide an update on the Hive Programme	*(Report of the Deputy Group Chief Executive, SRO for Hive Programme enclosed)*
	9.4 To receive the NHSE 2023/24 elective priorities' Board checklist	*(Report of the Group Deputy Chief Executive enclosed)*
10.	**Strategic Review**	
	10.1 To receive an update on strategic developments	*(Report of the Group Executive Director of Strategy enclosed)*

11. Governance

11.1 To receive the Annual Infection Prevention Control Report	*(Report of the Group Chief Nurse enclosed)*
11.2 To receive the Annual Safeguarding report	*(Report of the Group Chief Nurse enclosed)*
11.3 To receive an update on the response to the Ockenden report	*(Report of the Group Chief Nurse enclosed)*
11.4 To receive an update report on MFT's Risk Management Framework and Strategy	*(Report of the Joint Group Medical Director enclosed)*
11.5 To receive the updated Group Risk Appetite Statement	*(Report of the Joint Group Medical Director enclosed)*
11.6 To receive the Board Assurance Framework	*(Report of the Group Executive Director of Workforce and Corporate Business enclosed)*
11.7 To receive the Terms of Reference for the Strategic Projects Scrutiny Committee	*(Report of the Group Executive Director of Workforce and Corporate Business enclosed)*
11.8 To receive proposed amendments to MFT's Constitution	*(Report of the Group Executive Director of Workforce and Corporate Business enclosed)*

12. Date and Time of Next Meeting

The next meeting will be held on Monday 11th September 2023 at 2:00pm

13. Any Other Business

Agenda Item 3

NHS Manchester University NHS Foundation Trust

MINUTES OF THE BOARD OF DIRECTORS' MEETING

Meeting Date: 9th May 2023

(PUBLIC)

Present:	Kathy Cowell (Chair) (KC)	Group Chairman
	Mark Cubbon (MC)	Group Chief Executive
	Trevor Rees (TR)	Deputy Group Chairman
	Angela Adimora (AA)	Group Non-Executive Director
	Darren Banks (DB)	Group Director of Strategy
	Gaurav Batra (GB)	Group Non-Executive Director
	Peter Blythin (PB)	Group Director of Workforce & Corporate Business
	Julia Bridgewater (JB)	Group Deputy Chief Executive
	Jenny Ehrhardt (JEh)	Group Chief Finance Officer
	Nic Gower (NG)	Group Non-Executive Director
	Luke Georghiou (LG)	Group Non-Executive Director
	Cheryl Lenney (CL)	Group Chief Nurse
	Damian Riley (DR)	Group Non-Executive Director
	Mark Gifford (MG)	Group Non-Executive Director
	Bernard Clarke (BC)	Associate Medical Director
	Tom Rafferty	Director of Strategy
In attendance:	Nick Gomm (NGo)	Director of Corporate Business/ Trust Board Secretary

66/23 Apologies for Absence

Apologies were received from Chris McLoughlin, David Furnival, Toli Onon and Jane Eddleston.

KC welcomed BC and TR to the meeting. BC was representing the Joint Group Medical Directors and TR was representing the Strategy Directorate whilst DB is covering the Chief Operating Officer role.

67/23 Declarations of Interest

No specific interests were declared for the meeting.

68/23 Minutes of the Board of Director's meeting held on 13th March 2023

The minutes of the Board of Directors' (Board) meeting held on the 13th March 2023 were approved.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the minutes.	n/a	n/a	n/a

69/23 Patient Story

CL introduced a film which featured a Clinical Nurse Specialist describing her externally funded project to improve cataract services for patient with communication difficulties.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the patient story.	None	n/a	n/a

70/23 Matters Arising

There were no matters arising.

71/23 Group Chairman's Report

KC began by welcoming MC to his first Board meeting and the gave an overview of a number of matters of interest to Board members.

As part of Equality, Diversity and Human Rights week, MFT colleagues are being asked to contribute to the refresh of the Trust's Diversity Matters strategy.

The Board Governance review has now concluded, and the outputs will be implemented along with any recommendations from the external Well Led developmental review which will take place in the Autumn.

MFT has gained Investing in Volunteers accreditation – the UK standard for good practice in volunteer management. This accreditation demonstrates to the Trust's volunteers and potential volunteers, how much they are valued, and validates MFT's commitment to volunteering within the organisation.

KC recognised the contribution of MFT's workforce in the context of the International Day of the Midwife on May 5th, International Nurses Day on Friday 12th May, and the National Operating Department Practitioner Day on the 14th May.

KC concluded her report by highlighting the ongoing conflict in Sudan and the work between MFT and NHS England to ensure the Trust's staff who are affected by the conflict were appropriately cared for.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the Group Chairman's verbal report.	None	n/a	n/a

72/23 Group Chief Executive's Report

MC began his report by expressing his enthusiasm for his new role as Chief Executive an highlighting the exciting opportunities for MFT which lie ahead. He is focusing on four areas of work:

- Reducing delays for patients who are referred to or attend any one of our sites for treatment, while striving to deliver high quality, effective and safe care
- Managing our resources effectively and living within our means

- Ensuring that each member of staff has the support required to do their job to the best of their abilities
- Maximising the impact of Research & Innovation so that our patients can benefit from innovative technologies and treatments which deliver better outcomes

MC described the importance in maximising the output from MFT's Hospitals, MCSs, and LCOs and thanked everyone who had co-ordinated the response to the recent periods of industrial action. He expressed disappointment at the results of the recent CQC inspection of maternity services at the Trust and confirmed that immediate action had been taken to address the deficiencies highlighted.

MC concluded by highlighting his current top three concerns: the scale of the elective backlog, noting that each number represented a patient waiting too long for treatment; the financial challenge for 2023/24; and the CQC's warning notice regarding maternity services.

In response to a question from TR regarding the potential % improvement by benchmarking against the national 'Getting It Right First Time' (GIRFT) programme, MC explained that it would improve the productivity of the Trust and work was already underway to focus on it.

In response to a question from MG regarding the new Integrated Performance Report, MC stated that the new report would be presented at the July Board of Directors and would enable to Board to become more data-driven in its approach to performance monitoring.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the Group Chief Executive's verbal report.	None	n/a	n/a

73/23 Report on MFT's current operational performance against national standards and planning requirements

DB presented the report which provided an update on MFT's operational performance.

There continues to be concerted efforts across MFT to shorten waiting times. Progress made in reducing MFT's longest waits has been significantly impacted by the recent industrial action despite best efforts to mitigate the loss of operating lists and clinics. There were therefore 973 patients waiting more than 78 weeks at the end of March, which was c. 300 more than had been planned. Despite further operational pressures, the commitment remains to reduce this number to zero by the end of June and to continue work towards no patients waiting more than 65 weeks by April 2024, in-line with national expectations. Work continues to validate all waiting lists to ensure that the patients on lists still require their procedures and that they are communicated with throughout. A 'deep dive' on elective care has been held, led by Group Executives, Hospital / MCS / LCO Chief Executives and the relevant Corporate Directors, and a series of Improvement Boards have been constituted.

DB described the progress made on reducing the number of patients with suspected cancer waiting over 62 days for their treatment. At the end of March there were 274 patients against a plan of 267 with the industrial action again having an impact on work to reduce this number further. The total waiting list for patients on suspected cancer pathways has, though, reduced by 48% since its peak in September, which means patients are being diagnosed and treated faster than previously despite there being more than double the number of referrals compared to previous years.

DB highlighted issues with the head/neck and gynaecology pathways where some specific bottlenecks remain. Saint Mary's is looking at using the Christie to support the gynaecology work.

DB explained that MFT's hospitals have seen urgent care pressures easing slightly since mid-January with a reduction in the number of attendances and additional wards being opened. This has resulted in improved waiting times for patients in our emergency departments and a reduction in handover delays with ambulance crews. 60% of patients waited 4 hours or less in our emergency departments in the final quarter of last year which remains significantly below the national standard of 95%. The minimum expectation for 2023/24 is that at least 76% of patients are seen within 4 hours. Challenges remain with flow through the Trust's hospitals; admission rates from emergency departments are relatively high (reflecting the increased acuity of patients attending MFT's hospitals), as are bed occupancy rates.

The number of patients with 'no reason to reside' in MFT's hospitals) has remained static at around 330 since December against a target of 240. Targeted transformation work continues through enhancing Same Day Emergency Care (SDEC) services, increasing virtual ward capacity and roll out of the 'back to basics' part of the Resilient Discharge Programme across all wards. A locality-wide strategy is in development too through a data-driven process to reset priorities and continue to deliver improvements for patients.

DB explained that the number of patients waiting for diagnostic tests has seen a growing waiting list trend since September 2022 with a significant increase in the number of patients waiting for CT, MRI and non-obstetric ultrasound scans (NOUS) as well as audiology tests. Additional capacity has been in place through Community Diagnostic Centre programme and weekend scanning to support a reduction in the overall waiting lists. There has been a focus on supporting timely diagnosis for patients on cancer pathways, with improvements seen in MRI and CT from an average of 13 days to 8 days. A dedicated taskforce has been established to ensure that recent improvements continue.

In response to a question from DR regarding the 'winter wards', JEh confirmed that they were still open in MRI and at NMGH but the ones at Wythenshawe had been closed. The funding of the winter wards was accounted for in the financial plan for 2023/24.

JB emphasised the importance of delivering improvements in Urgent and Emergency Care (UEC) and KC agreed, noting the importance of Hive as an enabler for all MFT's improvement work.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report	None	n/a	n/a

74/23 Group Chief Finance Officer's Report (including end of year position)

JEh introduced the report which presented MFT's financial position at the end of the 2022/23 financial year.

At the financial year-end, the Trust had delivered a surplus of £0.1m against the plan to breakeven. This reflects an in-month surplus of £6.7m. The achievement of the control for 2022/23 has relied heavily on the contribution of non-recurrent support (additional non-recurrent income, non-recurrent savings within the WRP and review of balance sheet.

In March 2023 total expenditure was £324.9m, an in-month increase of £97.8m. This included two large year-end adjustments for pension liabilities of £58.5m (a normal year-end adjustment) and for the assumed non-consolidated additional AfC pay award of £51.8m, relating to the now rejected settlement of the nurse's strike action. These adjustments are reflected by an equal amount of income. Excluding these adjustments there has been a reduction in expenditure reported in month 12 of £12.5m, compared to the monthly run rate. Much of this has been through the use of non-recurrent actions in order to achieve the planned breakeven figure for the year. The impact on run rates is such that there will be an expected increase in the first months of 2023/24 when the Trust has limited ability to mitigate expenditure through these non-recurrent means.

As at 31st March 2023, the Trust had a cash balance of £241m. The cash balance has remained reasonably constant compared to the balance of £245m at 28th February 2023. The cash balance at the end of March was broadly in line with the £248m forecast – the key reason for the reduction being higher than forecast trade creditor payments.

The Trust's total capital plan value for 2022/23 was £136.4m. For the year ended 31st March 2023, total expenditure was £150.97m against this plan, an overspend of £14.6m. £8.5m of the overspend relates to the approved increase to the GM envelope and the remainder predominantly relates to PDC funding awarded during the year, additional to that included in the plan.

For the year ended 31st March 2023, Right of Use (ROU) Assets charged against IFRS 16 CDEL total £25.1m, against a national allocation of £139.8m. This position reflects the impact of the delayed NHS guidance until over halfway through 2022/23, updated assumptions on the managed equipment service (MES) contracts, and significant delays in the supply chain and lease commencement process

The Waste Reduction programme delivered its target of £117.2m, although a significant percentage of this was through non-recurrent savings.

KC thanked JEh and her team for delivering a balanced position at year-end.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report.	None	n/a	n/a

75/23 Update on Hive Programme

JB presented the report which provided an update on delivery of the Hive programme which has been delivered through a 'clinically-led, operationally-delivered, digitally-enabled' approach.

Throughout life of the Hive Programme, Deloitte have been providing external assurance to the Board via formal gateway reviews. The fifth and final Gateway review report was discussed at the EPR Scrutiny Committee on 26th April and commended the progress made so far with implementation and stabilisation**.** Deloitte highlight the design and implementation of a single, digital transformation strategy as their key recommendation, to ensure that there is a single governance process in place to manage MFTs new digitally enabled operating model. The launch of the Delivery Authorities aligns to this recommendation and will help provide a single route for prioritisation and delivery of the MFT 23/24 Plan and a firm platform for future delivery.

MFT will upgrade to the November 22 version of Epic in May 23. Significant planning and testing of the upgrade version has already taken place to ensure it is compliant to MFT bespoke workflows and to assess the timing and duration of downtime that will be required for the transition. The date and time of the upgrade will be agreed shortly when all testing has been completed.

Training teams across Hive and other systems continue working with all stakeholder groups to develop Future State Training. The teams have been trained in the production of eLearning, and lesson plans across the professions have been signed off with stakeholders. The teams are now working on bringing the training materials into an eLearning format so that they are of a higher standard and easier to access. Over the next three months the remaining materials will be signed off and launched within the Learning Management system across each profession.

JB confirmed that: at the last Group Risk Oversight Committee (GROC), the patient safety risk associated with Hive was downgraded to a 12. Implementation of the third-party system for blood transfusion was moved to optimisation before Go Live, as it was not safe to proceed, and the legacy laboratory system was retained. The workarounds that are required as a result are proving difficult for both laboratory and clinical staff. Given the substantive solution will take approximately 12 months to deliver, a review of the current workarounds has taken place with a number of recommended actions required for implementation. Given this risk affects all stakeholders, and needs to be managed and overseen across teams, the risk has been escalated to a level 15 (high level) on the Trust Risk Register and has been reported into GROC ensuring Board level oversight.

JB highlighted in the report the list of non-financial benefits enabled by Hive and explained that £20m of financial benefits were also expected.

In response to a question from DR regarding the MyMFT application, JB explained that there had been significant take up from patients and it has enabled patients to provide information to clinical teams prior to appointments.

In response to a question from KC regarding the potential of MyMFT to encourage feedback from patients, JB confirmed that MyMFT features in discussions about future developments but there is a need to prioritise the focus of the programme at the moment. CL added that MyMFT has considerable functionality and is useful for appointment management. The ability to have 1 to 1 conversations between the patient and their consultant is not in place at the moment.

In response to a question from MG regarding Hive's role in the transformation of services, JB explained that the established Design Authorities were key to this and that consideration of the opportunities from Hive was embedded within transformation discussions.

MC emphasised the role that the data produced by Hive will play in driving improvement work across the Trust. Hive has enabled a single Patient Treatment List (PTL) for cancer and this has helped drive down cancer waiting times since September 2022.

LG and AA noted the importance in using the Communications team to continue to articulate the benefits and opportunities from Hive and JB and PB confirmed that this was happening.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report	None	n/a	n/a

76/23 Reports from the Chairs of the Board of Directors' Scrutiny Committees

EPR Scrutiny Committee (EPRSC)

GB described the business and discussions at the EPRSC held on the 26th April 2023 including: the positive assurance received from Deloitte, who referred to the Go-Live as an 'exemplar'; the analytic support required to maximise the benefits from Hive; and the need to increase the digital maturity of the whole of the Trust, and its workforce, to embed Hive within the next phase of the Trust's development.

Audit Committee

NG described the business and discussions at the Audit Committee held on the 12th April 2023 including: the robustness of the Trust's control framework; agreement of the focus for the External Audit of 2022/23; agreement of the Internal Audit Plan for 2023/24; and agreement of the Counter Fraud plan for 2023/24 which will have an enhanced focus on fraud risks associated with procurement activity.

Human Resources Scrutiny Committee (HRSC)

AA described the business and discussions at the HRSC held on the 18th April 2023 including: review of the Clinical Excellence Awards and their link with Gender pay gap issues; the impact of, and mitigating actions taken during, the recent industrial action; medical appraisals; culture improvement work underway at Saint Mary's; lessons learned from the staff survey results; and the recent Ofsted inspection of the nursery on the Oxford Road Campus.

Finance and Digital Scrutiny Committee (FDSC)

YT described the business and discussions at the FDSC held on the 25th April 2023 including: MFT's Month 12 financial position; the recognition that breakeven was obtained through non-recurrent savings and the need to address this in the WRP for 2023/23; the lack of confirmation regarding funding from the National Hospital Programme for the redevelopment of NMGH; the rationale for, and effectiveness of, the recent Hive downtime period; and the lessening impact of Hive on performance figures as it becomes fully embedded.

Quality and Performance Scrutiny Committee (QPSC)

DR described the business and discussions at the QPSC held on the 18th April 2023 including: a presentation from MFT's vascular service; a deep dive into cancer performance; Saint Mary's progress with implementing the Ockenden improvement actions and their response to the CQC inspection; and a review of the terms of reference for the Committee, with the explicit inclusion of health inequalities as an in-scope area of work for the Committee.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the verbal reports from the Scrutiny Committee chairs.	None	n/a	n/a

77/23 Update on strategic developments

TRa highlighted a number of topics covered in the report which provided an update on strategic issues nationally, regionally, and within MFT.

The report of the review of integrated care systems undertaken by Rt Hon Patricia Hewitt was published on 4 April 2023. It makes a number of recommendations including:

- Increasing the proportion of ICS funding spent on prevention by at least 1% over the next 5 years
- Reducing the number of national targets, and allowing ICSs to supplement these with local priorities
- Greater autonomy for the most effective ICSs
- "Radical reform" of the GP contract to allow local flexibility and to support Primary Care Networks
- New payment models to support population health management and improve productivity

The GM ICP Strategy was approved by the GM ICP at the end of March 2023. Each ICB is also required by NHS England to produce a 5-year Joint Forward Plan (JFP) that sets out how it will exercise its functions. The draft JFP is to be approved by the ICB meeting on 21st June ahead of submission to NHSE.

Activities to disaggregate NMGH from the legacy PAHT continue.

Commissioner approval has now been received for the disaggregation of Gastroenterology, Cardiology, Rheumatology and some Urology services.. Work has commenced to seek commissioner approval for the next phase which includes ENT, Urology, Trauma & Orthopaedics and DEXA scanning. Proposals will be jointly presented to Scrutiny Committees and

commissioners in the affected localities in the summer.

In response to a question from TR regarding GMICB's workforce, MC confirmed that they have been asked to make a 30% reduction in their staff costs and are undertaking a piece of work to assess where their staff can best make a positive impact – whether at system or 'place' level. The GM Provider Federation Board is also looking at where GM ICB staff can support with provider initiatives.

Board Decision:	Action	Responsible officer	Completion date
The Board noted the report	None	n/a	n/a

78/23 MFT Annual Plan 2023/2024

TRa introduced the report which sought approval for MFT's Annual Plan for 2023/24.

The Annual Plan sets out what the Trust intends to do in the coming year in order to respond to immediate challenges and to make progress towards delivering its longer-term vision, strategies, and strategic aims.

TRa described the process for creating the plan and outlined the ways in which the delivery of the plans will be monitored throughout the year. As in previous years, a year-end review of the Annual Plan will be undertaken in December and presented to the Council of Governors.

KC confirmed that the financial plan element of the Annual Plan had been approved at the Private meeting of the Board earlier in the day.

DB emphasised the need to continue to refer back to the plan throughout the year to ensure that intended progress in being made.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the Annual Plan for 2023/24.	None	n/a	n/a

79/23 Delegate authority to the Audit Committee for sign-off of the MFT Annual Report and Annual Accounts for 2022/2023

JEh presented the report which sought delegation of authority, from the Board of Directors to the Audit Committee, to sign off MFT's Annual Report and Annual Accounts. This is necessary to ensure that the documents can be submitted to NHS England in line with the national reporting timetable i.e by 30th June 2023.

Board Decision:	Action	Responsible officer	Completion date
The Board delegated the authority for the approval of the Annual Report and Accounts for 2022/23 to the Audit Committee.	None	n/a	n/a

80/23 Complaints report (Q4)

CL introduced the report which covered Patient Advice and Liaison Service (PALS) and Complaint activity across MFT during Q4 (1st January – 31st March) 2022/23.

2,313 PALS concerns were received in comparison to 2,208 received in the previous quarter, an increase of 4.8% (105). This is also an increase of 11.8% (244) from the 2069 received in Q4, 2021/22. 516 new complaints were received in comparison to 549 received in the previous quarter, a decrease of 6.4% (33). This is, however, an increase of 20.8% (89) from the 427 received in Q4, 2021/22. Of the 516 new complaints received, 166 related to inpatient service, which is equal to the previous quarter. This is an increase of 19.4% from the 139 complaints relating to inpatient services for the same period in Q4 2021/22.

Wythenshawe, Trafford, Withington, and Altrincham Hospitals (WTWA) received the greatest number of complaints with 139 being received during this quarter; an increase of 13.9% (17) in comparison to the 122 WTWA received in the previous quarter. Of the 139 complaints received at WTWA, the main themes were 'Treatment/Procedure' and 'Clinical Assessment'.

The Trust has a target of 90% of complaints to be responded to within an agreed timescale and 87.1% of complaints were responded to within this agreed timescale compared to 88.5% in the previous quarter. 61 (11.6%) complaints investigated were upheld, 364 (69.2%) were partially upheld and 100 (19.0%) were not upheld.

The Parliamentary and Health Service Ombudsman (PHSO) closed 1 case during Q4 22/23, which was upheld. Wythenshawe, Trafford, Withington, and Altrincham Hospitals (WTWA) are currently completing the actions and recommendations from this. The PHSO did not open any new cases for investigation during this quarter.

There was a total of 117 (15.9%) re-opened complaints received, compared to 111 (14.1%) the previous quarter, and 74 (17.9%) in Q4, 21/22 • 44 virtual or face-to-face complaint local resolution meetings were held. This is a 18.9% increase compared to the 37 held previous quarter, and a 63.0% increase from the 27 held in Q4, 21/22.

The Complaints Scrutiny Group, attended by NG, met twice in the last quarter, and KC confirmed that NG had found his role on the Group provided him with greater insight for his role as a Non-Executive Director.

In response to a question from GB, CL confirmed that a raft of other patient experience data is collected and acted upon across the Trust, including the Friends and Family Test which replicates the 'Net Promoter' score used in other sectors. CL committed to reviewing Board reporting to consider whether a broader Patient Experience report, including complaints data, would be more beneficial in the future.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report	Consider format of report to included other patient experience information	CL	July 2023

81/23 Annual Nursing and Midwifery Revalidation report

CL introduced the report which provided an annual overview of Nursing and Midwifery Professional Revalidation at MFT for 2022/23.

Revalidation is now embedded within the nursing and midwifery profession having been a requirement since 2016. Nurses and midwives are encouraged to maintain a portfolio of evidence and feedback in preparation for revalidation. Nursing associates, who registered with the NMC since January 2019 are required to revalidate every three years, in line with nursing and midwifery. 15 nursing associates have successfully revalidated since April 2022.

Revalidation compliance is monitored by the Corporate Director of Nursing responsible for the NMAHP workforce and professional education portfolio. A monthly workforce report generated from the NMC register is utilised to inform the Trust's revalidation assurance process. Revalidation champions are established in each Hospital/MCS/LCO and are responsible for monitoring staff revalidation and supporting staff through the revalidation process. If member of staff fails to meet the revalidation requirement, their registration remains active for one month, prior to their registration expiring. In this situation the Trusts Professional Registration Policy would come into effect.

The total number of nurses, midwives and nursing associates who are employed by the Trust and have revalidated with the NMC in 2022/2023 is 2798 out of a total of 2802. The remaining five registrants who have not revalidated have requested an extension to revalidate from the NMC which has been granted. The Corporate Director of Nursing will monitor the conditions of this extension to ensure the nurses remain 'live' on the NMC register during this period.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the contents of the paper and actions taken to support Nurses, Midwives and Nursing Associates across the Trust to meet the Nursing & Midwifery Council statutory revalidation requirement.	None	n/a	n/a

82/23 Safer staffing

CL introduced the report which detailed the Trust's position, at the end of March 2023, against the requirements of the National Quality Board (NQB) Safer Staffing Guidance for adult wards 2016, and the NHS Improvement (NHSI) Developing Workforce Safeguards Guidance, published in October 2018. t is a national requirement for the Board of Directors to receive this report bi-annually to comply with the CQC fundamental standards as outlined in the well-led framework. The previous report was received by the Board of Directors in November 2022.

The Trust workforce position has continued to improve over the last 6 months. Both domestic and international recruitment programmes have resulted in 888wte registered nurses and midwifes joining the organisation. The Trust has benefited from an average monthly nursing and midwifery starters rate of 126.9wte since September 2022. The total number of nurses and midwives joining the Trust in 2022/23 is 1395.3wte.

This improved workforce position, is supported by the number of internationally recruited nurses and midwives recruited via the well-established overseas recruitment campaign. The total number of international nurses and midwives joining the Trust in 2022/23 is 522wte.

At the end of March 2023, there were a total of 348.6wte (3.7%) registered nursing and midwifery vacancies across the Trust which remains consistent with the September 2022 vacancy position. However, during this time the nursing workforce has grown more than this movement suggests. Recruitment has kept pace with turnover and increases in funded establishment (47.1wte) demonstrating an overall improving picture that is expected to continue throughout 2023 due to the numbers in the domestic and the international recruitment pipeline. The Trust's overall nursing and midwifery vacancy rate (3.7%) is much lower than the national vacancy rate of 10.8% and the Northwest vacancy rate of 7.3%.

At the end of March 2023, the 12-month rolling turnover rate for registered nurses and midwives was 13.1%, this is an increase since September 2022 when the rate was 12.4%. The trust turnover rate is lower than the current national turnover rate for nursing and midwives in acute NHS trusts which is 14.7%.

Sickness rates had continued to reduce from 10.2% for registered nursing and midwifery staff and 14.0% for unregistered staff in Q3. At the end of March 2023, rates reduced to 6.4% and 9.6% for unregistered staff.

There are 110 domestic nurses and midwives in the recruitment pipeline expected to start before the end of June 2023. This number will increase in Q3 when the Trust sees the largest number of graduate nurses, midwives and AHP starters.

At the end of March 2023, the AHP vacancy position was 43.5wte (2.7%). The turnover rate for registered AHPs was 8.9% in March 2023. Sickness absence rates for registered AHPs in March 2023 was 4.7%. This is a decrease from sickness in September 2022 when the rate was 5.2%.

At end of March 2023, band 2 and band 3 nursing and midwifery support worker vacancies totalled 460.2wte (14.7%). During this period there has been an increase in starters however the continued leaver rates have slowed the impact to our vacancy position. It is anticipated now that the band 2 management of change process has drawn to a conclusion and the opportunity for staff to progress to a band 3 position, we predict a reduction in leaver rates and estimate a reduction in vacancies over the next 6 month. There has been initial evidence of this trend since December 2022.

Launched in May 2022, the band 2/3 NA and MSW management of change (MOC) process was undertaken to determine the number of band 2 clinical support staff who were undertaking clinical duties and working in roles aligned to agenda for change band 3. Staff were given the opportunity to put forward evidence to demonstrate they are currently working to a band 3 job description. Since the launch 1,661 (77.5%) existing band 2 staff have demonstrated they are undertaking clinical duties and have been aligned to a band 3 role. The MOC has now concluded. 483 (22.5%) staff who were eligible to undergo a skills assessment will remain in band 2 positions. These staff have been given the opportunity to upskill and move into band 3 roles in the future.

The bi-annual ward Safer Nursing Care Tool (SNCT) census collections were undertaken in March and November 2022. The results have provided assurance that 90% of ward establishments are aligned to the SNCT recommended establishment. This is an improved picture (6%) from the census results taken prior to the pandemic and reflect the investment in nursing posts in areas that were found to fall under the recommended safe staffing threshold.

Following the November 2022 census collection 13 clinical areas were shown to have a funded establishment 10% or more below the SNCT recommenced establishment. 8 of these areas were also highlighted as falling below the recommended funded establishment following the March 2022 census. The Directors of Nursing are reviewing these findings and taken action to align the establishment sin these areas with the recommendations. It should be noted that post pandemic the patient acuity has increased in these areas which indicates a requirement for an increased establishment.

NICE guidance for safe midwifery staffing for maternity settings recommends a systematic process is undertaken to calculate the midwifery staffing establishment. ‘Birth-rate plus’ is a toolkit which is endorsed by NICE and the Royal College of Midwives PDF page 132 5 as the recommended methodology for Midwifery workforce planning. A review of the workforce across Greater Manchester was commissioned by Greater Manchester and Eastern Cheshire (GMEC) Local Maternity System (LMS). SM MCS received the report in April 2023 and are considering the recommendations to inform the workforce model at each site. A detailed report will be provided to the Board of Directors once this has been finalised.

Further to the CQC inspection where concerns were raised about skill mix and safe staffing, an action plan is in place within which workforce and safe staffing is an integral workstream. Progress on these workstreams will be managed through the SMH PMO. The service will be taking actions to ensure sufficient numbers of skilled and experienced midwifery staff appropriately assess and care for women and mitigate risks in a timely manner.

In response to a question from DR regarding whether the increase in 'red flag' reporting was due to maintaining vacancies, CL clarified that there was no vacancy freeze in place for nursing and that the increase is due a number of short term absences over the period in question.

AA sought assurance about the extent to which MFT is in line with the national figures of nurses planning to leave the NHS in the next two years and MFT's plans to extend the working life of its nurses. She also asked about the age profile of nurses leaving MFT. CL and PB committed to providing further information at the HRSC.

In response to a question from TR regarding the table in 6.20 in the report, CL committed to including, in the next Safer Staffing report, the action being taken by Saint Mary's to address the issues with staff numbers and staff mix raised by the CQC.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report	Further information to be provided to HRSC regarding the numbers, and age profile, of nurses leaving MFT.	PB/CL	June 2023
	Actions being taken by Saint Mary's to address the issues raised by the CQC regarding staff numbers and staff mix to be included in the next Safer Staffing Report	CL	November 2023

83/23 Update on the CQC Saint Mary's oversight arrangements

CL introduced the report which detailed the actions being taken following the CQC's inspection of Saint Mary's Managed Clinical Service (SMMCS) in March 2023.

On 23rd March 2023 the Trust was notified that the CQC had formed the view that the quality of health care provided by the maternity services required significant improvement in the following areas:

- Triage: The service did not operate effective and timely triage process to protect women, birthing people, and newborns.
- Delays: The service did not facilitate timely access to appropriate treatment and birth settings for women, birthing people, and newborns.
- Staffing: The service did not always have enough sufficiently skilled and experienced midwifery and medical staff to appropriately assess and care for women and birthing people and mitigate risks in a timely manner.

A regulation 29A (warning notice) was issued to MFT (appendix 1) The maternity services are required to make the significant improvements identified above regarding the quality of healthcare by 23rd June 2023.

Initial briefings have been provided to the MFT Board of Directors, Quality and Performance Scrutiny Committee, Group Quality and Safety Committee, the Local Maternity and Neonatal System on behalf of the ICB, GM Integrated Care Board and the Northwest Regional Chief Midwife on behalf of NHSE.

A governance structure and project management office have been established to provide executive oversight, receive assurance, and apply scrutiny of the effectiveness of actions being taken by SM MCS, including the scrutiny by external stakeholders and regulators.

An Executive led Maternity Oversight Group (MOG), co- chaired by the Chief Nurse and Deputy Chief Executive, has been established to oversee and assure the response of SM MCS. The MOG meets alternate weeks. The group has external stakeholders and MVP in the membership.

The SM MCS Operational Delivery Group, chaired by the Saint Mary's MCS CEO, meets weekly and reports fortnightly into the Maternity Oversight Group using exception reports related to the progress of each of three workstreams.

Three workstreams (Triage, No Delays and Safer Staffing) corresponding to the concerns identified have been developed which report to the Operational Delivery Group. The workstreams have identified Director leads from the Senior Leadership Team and each report weekly on progress into the Operational Delivery Group.

SM MCS have developed and submitted a comprehensive CQC compliance action plan related to the specific concerns. The Compliance Action Plan was submitted to the CQC for review on 31st March 2023. The CQC have acknowledged the plan. The action plan corresponds with the timescale for compliance (23rd June 2023) set by the CQC.

The Project Management Office (PMO) is tracking the completion of actions and SM MCS have set up the PMO to coordinate the response and work of the workstreams, namely triage, flow and safer staffing. Focus has been on implementing the action plan and identifying indicators/measures of success, and collating evidence, to provide assurance to the Board of Directors and the Regulators.

The compliance action plan has been submitted to the CQC and an update plan is programmed for 27th April. 4.9. The MOG accepted the plan and have requested evidence of improvement at the next meeting on the 26th of April.

CL gave an overview of the specific actions in place to address each of the areas of concern raised by the CQC and explained that the composite maternity risk, reviewed at the Group Risk Oversight Committee, was being changed to enable enhanced assurance of all the risks associated with maternity. She also reminded Board members of the wider assurance regarding maternity services which was provided to the Board through the regular reports regarding compliance with Ockenden recommendations.

Progress is already being seen in the actions taken so far with delays reducing significantly across the maternity pathway. A dashboard is being developed, incorporating new metrics which have been specifically designed to monitor progress with the action plan.

In response to a question from KC regarding the timescale for triage by a doctor, CL confirmed that additional junior doctors had been put into the service to address this issue. She also explained that RCN guidance included no stipulation that the triage had to be done by a doctor rather than a midwife, however the BSOTS guidance did stipulate a 15 minute target for triage by a doctor if required. KC stated that MFT need to be compliant with whatever standards the CQC are using to assess the service.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the significant concerns identified by the CQC; the actions being taken by the Trust and the Saint Mary's MCS in response and, the governance structure now in place to gain assurance and monitor improvement.	None	n/a	n/a

84/23 Receive and approve the NHSI FT self-certification requirements

PB introduced the report which sought confirmation of, MFT's compliance with the following conditions of the NHS Provider License: G6(3), G6(4), FT4(8), and CoS7(3) (Declaration B). PB highlighted the evidence contained in the report to support confirmation.

Board Decision:	Action	Responsible officer	Completion date
The Board approved the proposed Self Certification for Condition G6(3), Condition G6(4), and Condition FT4(8). For CoS7(3), declaration B was confirmed.	None	n/a	n/a

85/23 NHS Staff Survey

PB introduced the report which presented MFT's Staff Survey results from the 2022 survey. There were 8,304 completed surveys, giving a response rate of 30.2% (30% in 2021). The median response rate for the benchmark group was 44%.

The Trust staff engagement score is 6.5 compared to 6.7 in 2021. MFT is below the sector average score for 5 of the 7 NHS People Promise elements and 2 of the themes with "We are safe and healthy" and "We are always learning" staying the same as 2021. As part of the We are safe and healthy element there is a -2.0% difference compared to the benchmarking group, with MFT reporting at 26.1% compared to 28.1% in staff personally experiencing harassment, bullying or abuse at work from patients / service users, their relatives, or other members of the public. Staff engagement and morale themes have both shown a statistically significant change with morale at 5.4 in 2022 compared to 5.5 in 2021.

For questions contributing to the Workforce Race and Equality Standards (WRES) the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months has declined for both white and all other ethnic groups since 2021. The percentage of staff believing that the organisation provides equal opportunities for career progression or promotion has declined for white staff and improved for all other ethnic groups. The percentage of staff experiencing discrimination at work from manager / team leader or other colleagues in the last 12 months has shown an increase for white staff and a decline for all other ethnic groups.

For questions contributing to the Workforce Disability Equality Standards (WDES), there has been a decrease in the percentage of staff with a long-term condition experiencing harassment, bullying and abuse from managers 22.3% to 21.6% and from other colleagues from 29.9% to 27.1% However, there has been a decline for both those with and without a long-term condition who believe that MFT provides equal opportunities for career progression or promotion.

For 2022, seven local questions relating to Hive were introduced as a baseline to track workforce related benefits which can then be measured before and after Hive implementation through the annual staff survey.

The HR Scrutiny Committee (HRSC) on 18th April 2023 discussed the detail of the report and received assurances about the actions being taken to support a programme of work over the coming months centred on a 'listening well' organisational strategy. The Organisational Engagement Plan is currently being finalised and will be discussed at the next Workforce Scrutiny Committee (WSC) in June 2023. Work is also underway to assess local Equality, Diversity, and Inclusion data for each Hospital / MCS / LCO / Corporate Service to understand the lived experience of staff with protected characteristics.

The 2022 results will be included in Accountability Oversight Framework discussions being led by the Group Chief Operating Officer with the support of Group Executive Directors. To support a consistent approach to action planning and goal setting, a revised 'Staff Survey Action Plan Playbook' has been circulated. This supports leaders and managers to work through a four-stage process in developing their plans.

Work will continue locally across the Hospitals / MCSs / LCO / Corporate Services to create 'a feel-good factor' for staff. Priority work will focus on staff recognition and acknowledging staff for their contributions to the Trust. Examples initiatives include, employee / team / leader of the month, staff awards, newsletters celebrating staff achievements, celebration of professional days, and staff thank you cards from Hospital / MCS / LCO Corporate Services Senior Leadership Teams. Further examples include festivals of belonging, wellbeing rooms, Kindness Weeks, allyship training, and 'Let's Talk about Race' workshops to foster an inclusive culture.

MC noted that there are many opportunities to improve the staff experience, and these will be acted upon. There will also need to be an honest approach taken for issues where solutions aren't apparent, for example the lack of sufficient car parking availability on some sites.

LG pointed out that lower response rates can often result in more negative results to surveys and GB asked to see the results in the context of a number of previous years' results. KC asked PB to pick up this latter point at the next WSC.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the report and endorsed the actions being taken.	Staff survey results to be presented to WSC in the context of a number of previous years' results.	PB	June 2023

86/23 Board Assurance Framework

PB introduced the Board Assurance Framework (BAF) which presents the risks which have the most potential to impede MFT's delivery of its strategic aims. The risks are also overseen by the relevant Board Scrutiny Committees.

In July 2023, the Board of Directors will receive the annual review of the RMFS and will be asked to confirm the Risk Appetite Statement for the next year. The Board of Directors will also be requested to review the principal risks to ensure that they continue to cover the risks most likely to impede delivery of MFT's Strategic Aims.

The design and format of the BAF, and the way in which strategic risks are reported to the Board, will be enhanced following the conclusions of the review of the RMFS to ensure better oversight for the Board of Directors and its Scrutiny Committees. This will include acting on any recommendations from Internal Audit's annual review of the BAF which is currently underway.

KC noted that the agendas of Scrutiny Committees would be informed the risks aligned to them.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board accepted the latest BAF (April 2023)	None	n/a	n/a

87/23 Scrutiny Committees' Terms of Reference

PB introduced the report which sought ratification for the terms of reference of the following committees of the Board:

- Audit Committee
- Charitable Funds Committee
- EPR Scrutiny Committee
- Finance and Digital Scrutiny Committee
- Workforce Scrutiny Committee (previously HR Scrutiny Committee)
- Quality and Performance Scrutiny Committee (QPSC)
- Group Risk Oversight Committee
- Remuneration Committee

PB highlighted an error in the proposed terms of reference for the QPSC – expected attendance at the meeting from Committee members is 66%, not the 75% stated in the report.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board ratified the terms of reference for each Committee.	None	n/a	n/a

88/23 Board of Directors' Register of Interests

PB introduced the report which presented the Board of Directors' Register of Interests.

Board Decision:	**Action**	**Responsible officer**	**Completion date**
The Board noted the Register of Interests.	None	n/a	n/a

89/23 Minutes of Board Sub- Committees held in March and April 2023

The Chairman asked the Board of Directors to note that the following meetings had taken place:

- Group Risk Oversight Committee held on 20th March 2023
- Charitable Funds Committee held on 28th March 2023
- Audit Committee held on 12th April 2023
- Quality and Performance Scrutiny Committee held on 18th April 2023
- Human Resources Scrutiny Committee held on 18th April 2023
- Finance and Digital Scrutiny Committee held on 25th April 2023
- EPR Scrutiny Committee held on 26th April 2023

Board Decision:	Action	Responsible officer	Completion date
The Board noted the minutes	n/a	n/a	n/a

90/23 Date and Time of Next Meeting

The next meeting of the Board of Directors will be held on Monday 10th July 2023 at 2:00pm

91/23 Any Other Business

There were no additional items of business.

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS' MEETING (Public)

ACTION TRACKER

Board Meeting Date: 9th May 2023		
Action	Responsibility	Completion date
Consider format of report to include other patient experience information	CL	September 2023
Further information to be provided to HRSC regarding the numbers, and age profile, of nurses leaving MFT.	PB/CL	September 2023
Actions being taken by Saint Mary's to address the issues raised by the CQC regarding staff numbers and staff mix to be included in the next Safer Staffing Report	CL	November 2023
Staff survey results to be presented to WSC in the context of a number of previous years' results.	PB	September 2023

Mrs Kathy Cowell, OBE DL
Group Chairman …… …../……./…….
Signature *Date*

Mr Nick Gomm
Director of Corporate Services / ……. …../……./……..
Trust Board Secretary *Signature* *Date*

Agenda Item 7

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Executive
Paper prepared by:	Mark Cubbon, Group Chief Executive
Date of paper:	July 2023
Subject:	Group Chief Executive Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	This report provides an overview of current issues of relevance to delivery of the Trust's Strategic Aims.
Recommendations:	The Board of Directors is asked to note this report.
Contact:	Name: Julie Gwilliam, Senior Executive Assistant Tel: 0161 276 4755

The purpose of this report is to provide a general update of matter

1. Visit from the Chief Executive of NHS England

On the 13th June, Ms Amanda Pritchard, Chief Executive of NHS England, visited Trafford General Hospital to find out more about the Trafford Elective Surgical Hub and the critical role it plays in MFTs elective recovery programme. Ms Pritchard was joined by Mr Richard Barker CBE, the Regional Director for the North of NHS England, and Ms Anne Gibbs, the Interim Chief Operating Officer of the Greater Manchester Integrated Care Board.

During the visit, Ms Pritchard met members of the Surgical Hub leadership team, before taking a tour of our facilities and meeting colleagues in our pre-assessment, surgical ward, theatres and high care areas. The visit went very well and I am grateful to all involved in making it a success.

2. NHS 75

July 5th marked the 75th anniversary of the creation of the NHS. This is of particular significance to MFT as Trafford General Hospital received the first ever NHS patient on that day in 1948. To recognise this occasion, seven MFT staff were selected to attend the national appreciation service at Westminster Abbey and invitations for MFT colleagues to attend the Manchester Civic Reception for NHS 75 have also been received.

Following a request made by the NHS Assembly, we were asked to generate a series of collaborative conversations with colleagues across MFT to consider questions related to the past, present, and the future of the NHS. Over 600 colleagues contributed their feedback and this was reflected in the report *The NHS in England at 75: priorities for the future* recent publication published by the NHS Assembly and NHS England in June.

3. Overview of Operational Delivery

The operating context in which we deliver our 23/24 plan remains challenging and the impact of Industrial Action presents further risk to our delivery trajectories. There are, however, a number of positive improvements to bring to the Boards attention, with further detail provided in the summarised Integrated Performance Report, to be presented later on the agenda.

In May 74.4% of patients (all types) attending our Emergency Departments were seen within 4hrs. The YTD performance is 72.3%. This compares to 61.9% delivered in March 23 and although we are delivering ahead of our agreed performance improvement trajectory, we continue to drive improvement across all sites to maximise the opportunity to reduce waiting times for our patients.

There have been improvements in compliance with Ambulance Handovers, in relation to the requirements in the annual plan. 50.4% of ambulance handovers were completed in under 15 minutes (45.1% in February) and 97.7% within 60 minutes (91.7% in February). These are levels of performance not seen

since November 2021 and are a result of hard work delivered in conjunction with the North West Ambulance Service and system colleagues.

The number of people on suspected cancer pathways waiting more than 62 days has, unfortunately, risen in recent months and was at 379 patients at the end of May against a trajectory of 310. At the end of March there were 274 people waiting over 62 days. Work continues to reduce this number in line with our trajectories and to deliver the national cancer waiting time standards. Delivery of the Faster Diagnosis Standard (for patients to receive a cancer diagnosis within 28 days) has been improving across recent months and was at 72.5% in May. The national expectation is for providers to deliver 75% by March 2024.

At the end of May, 46.3% of patients waiting for diagnostic tests were waiting less than 6 weeks. This remains lower than plan and a Diagnostic Improvement Programme has been established to oversee improvement at an individual test level.

There has been considerable progress made in treating some of our longest waiting patients, with 1,372 number of patients reported as waiting >78 weeks at the end of May. We remain focused on ensuring all patients who are medically fit and are waiting longer than 78 weeks, have confirmed appointments by the end of June. unless they have chosen a date shortly afterwards, due to their personal circumstances. We remain unable to offer dates to 23 patients for surgery due to a shortage of materials for corneal grafts but will do so as soon as they are available.

Over the past two months, we have held a series of ‘deep dives’ to review the delivery trajectories and the underpinning improvement plans. A series of actions have been agreed and will be overseen by the Chief Operating Officer.

4. Industrial Action

The junior doctors’ Industrial Action held 14th -17th June saw another huge effort from colleagues across the whole of MFT to ensure that as many services as possible were maintained during that period. Our priority was to ensure that our services remained safe whilst protecting as much provision as possible for patients with the most urgent clinical needs. We made every effort possible to minimise the impact of the industrial action on our elective programme, but it was necessary to reschedule the appointments of a significant number of patients due to be treated on those days.

I remain grateful to all colleagues who continue to go the extra mile to minimise the impact on our patients as much as possible, and I extend my thanks to our patients for their understanding.

5. Maternity services: CQC inspection

On 23rd June, in line with their prescribed deadline, we submitted evidence to the CQC of the improvement actions taken to address the concerns raised in their warning notice regarding maternity services at MFT. The team at St Mary’s Hospital / Managed Clinical Service has completed all the actions identified in their improvement plan and we can already see a positive impact on the maternity services we provide.

Prior to submission, the evidence was reviewed by the Executive Director Team and presented to an extraordinary meeting on the Quality and Performance Scrutiny Committee. There have also been peer review visits to our maternity services from NHS England's Local Maternity System and the University Hospital of Coventry and Warwickshire. Internal oversight arrangements will remain in place to ensure the improvements are sustained and the Board of Directors will continue to be updated.

6. Clinical governance stocktake and Well-led developmental review

We are in the process of appointing an external partner to undertake a stocktake of current clinical governance processes, identifying opportunities for development, and incorporate this into a broader, developmental Well-led review.

The work will take place from July to October and will consider our arrangements at Group level and within our Hospitals/Managed Clinical Services and LCOs. It will consist of a review of key documents, observation of committee and Board meetings, and interviews with MFT staff at all levels, including Board members. The final report and recommendations is planned to be presented to the Board at their meeting in November 2023.

7. Developing an overarching strategy for MFT

Currently, MFT has a broad range of strategies covering Clinical Services, Research and Innovation, Education and Training, MFT's People, Estates, Quality and Safety, Transformation, and Equality, Diversity and Inclusion. With the significant changes seen as a result of the Covid pandemic and the establishment of Integrated Care Systems, and the challenges we currently face in terms of operational performance, now is an opportune time to develop an overarching MFT Strategy which provides clarity and focus on the strategic priorities for the organisation, improves alignment across the Group, and supports delivery of our agreed priorities. The strategy will be developed with the involvement of Board members, staff and partners, followed by a period of wider engagement in early 2024. Engagement with the Council of Governors on this work will begin at its meeting on 12 July.

The planning round for 2024/25 will start in September 2023 before the strategy is finalised. A piece of work to create a shorter-term strategic plan will therefore take place, alongside the strategy development process, to provide some clarity on priorities over the next 18 months.

8. North Manchester General Hospital

In May, we were delighted the receive the news that the Department of Health and Social Care confirmed funding for the redevelopment of North Manchester General Hospital. We are now awaiting confirmation of the detail of the funding awarded so we can progress the development of a full business case. In the meantime, we continue to liaise with national, regional and local stakeholders to advocate on behalf of our patients and seek positive partnerships which will help us deliver our vision for the new hospital.

9. Sickle cell pilot

NHS England has confirmed that MFT will be one of 2 sites nationally to deliver a 2-year pilot for a Sickle Cell Hyper Acute Unit. MFT was chosen to be part of this pilot given the prevalence of sickle cell disease in the population that we serve. This reflects the diverse nature of the population in Greater Manchester and the fact that sickle cell disease disproportionately affects people of Black Caribbean or Black African heritage. It is therefore an important part of what we re doing to improve the health of local people and also address health inequalities.

The plan is to offer people experiencing sickle cell disease crises – when they suffer intense pain due to blood clotting in their arteries – 24/7 specialist support and expedited admission to a specialist unit that can offer pain relief quicker. Plans to establish this service – which should help to improve the quality of life with people who have the disease – are underway.

Our proposal has been shared with GM and NHS North West who are supportive and the MFT Sickle Cell and Thalassaemia Partnership Board is being kept informed on progress. The pilot will be linked to the developing work towards an all-age MFT strategy for these services.

10. Equality, Diversity and Inclusion Improvement Plan

Ensuring our Trust, our services, and our workforce promote equality, diversity and inclusion, and delivers improvement in health inequalities experienced by our local communities, is a key priority for MFT.

In June, NHS England published its Equality, Diversity and Inclusion (EDI) Improvement Plan which sets out a number or targeted actions which aim to:

- address discrimination, both direct and indirect.
- increase accountability of all leaders.
- support the levelling up agenda.
- make opportunities for progress equitable.

The publication of the EDI Improvement Plan provides an ideal opportunity to evaluate the progress we have made to date, undertake further engagement with our Staff Networks, and refresh both our MFT People Plan and EDI Strategy. This work is expected to be completed in the autumn and presented to the Board once finalised.

11. NHS Long-Term Workforce Plan

The NHS Long-Term Workforce Plan published on the 30th of June has been welcomed by the Trust. It is difficult to overstate the importance of the Plan in terms of how we ensure high quality care and work for our patients and staff in the future and we are taking time to fully understand how we can play our part in delivering it at MFT. Building on the strong links that we have with universities and higher education

providers will be key, as well as the work that are already doing to support less traditional routes into careers in the NHS.

Work is already underway to fully assess how the national plan can be best applied to inform the Trust's overall strategic direction, the refresh of the Trust's existing People Plan as well as planning more generally for the year ahead.

12. Top three concerns

My current top three concerns I would like to highlight to the Board are:

- The ongoing challenge to reduce the size of our waiting list, and our waiting times, for elective care. Continuing industrial action presents an additional challenge to the delivery of our elective recovery trajectory. We continue to focus on increasing our productivity and providing additional capacity as necessary to improve our performance and waiting times for patients.

- Our work to address our underlying financial deficit, and to achieve a recurrent balanced position, continues. Whilst we have a plan for a break-even position this financial year there is a significant amount of work required to deliver this. A huge amount of energy is going into this work across the organisation and we have secured some external support to support our efforts around waste reduction and the development of our 2 year financial strategy.

- The improvement work carried out in our maternity services in response to the CQC 29a Warning Notice we received is already having a positive effect on the experience of women who use our service. It is essential that we complete this improvement work and we will continue to closely monitor these services as well as ensuring that we share the learning from the CQC's findings across the organisation.

The above concerns are reflected in the principal risks within the Trust Board Assurance Framework.

13. Recommendation

The Board of Directors is asked to note this report.

Agenda Item 8

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Non-Executive Directors
Paper prepared by:	Group Non-Executive Directors Director of Corporate Business and Trust Board Secretary
Date of paper:	July 2023
Subject:	Reports from the Board of Directors' Scrutiny Committees: • EPR Scrutiny Committee held on 26th April 2023 • Audit Committee held on 20th June 2023 • Quality and Performance Scrutiny Committee held on 20th June 2023 • Workforce Scrutiny Committee held on 20th June 2023 • Finance and Digital Scrutiny Committee held on 27th June 2023
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	This report provides a summary of the Board of Directors' Scrutiny Committees. They contain detail of current issues of relevance to delivery of the Trust's Strategic Aims.
Recommendations:	The Board of Directors is asked to note this report.
Contact:	Name: Nick Gomm, Director of Corporate Business and Trust Board Secretary Tel: 0161 276 4841

EPR Scrutiny Committee (EPRSC)
Highlight Report

This report includes the key escalations and discussion points from the last Committee meeting of the EPRSC for consideration by the Board. The agenda of the meeting is included.

Committee meeting date	26th April 2023
Committee Chair	Gaurav Batra

KEY ESCALATION AND DISCUSSION POINTS

ALERT

n/a

ASSURE

Hive systems and processes are now largely stabilised.
There have been no patient harm incidents as a result of Hive implementation.
The Intensive Support Team reported that MFT's implementation of Hive was the best EPR implementation they had seen.
The final Deloitte assurance review was presented and highlighted exemplary programme governance and a successful transition from implementation to stabilisation and optimisation. An action plan is in place to address remaining recommendations from Deloitte.
The Pathway Councils remain to address issues which have emerged since go-live.
Further external assurance will be considered by the EPRSC later in 2023/24.

ADVISE

The 'November 22' upgrade of Hive will take place in June 2023.
At year-end, revenue costs for Hive were £0.8m below budget forecast. However, the underspend is largely offset by above budget service costs, unbudgeted NCA and GP reimbursement costs, and costs due to additional usage. Capital costs are £3m above budget primarily die to service provider resources not being in the budget setting plan.
Hive's 2023/24 budget is £10.4m above the original business case.
The Terms of Reference for the EPRSC were reviewed and agreed.

RISKS

The remaining strategic risk related to Hive (Potential impact on patient safety) was downgraded to a 12 at the Group Risk Oversight Committee in March 2023.

ACTIONS (actions required of the Board)

To note the discussions at EPRSC.

LEARNING

Learning with regard to Hive is shared across the Trust.

Meeting agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

EPR Scrutiny Committee

Wednesday 26th April 2023 at 2:00pm

MAIN BOARDROOM
COBBETT HOUSE

A G E N D A

1.	Apologies		
2.	Declarations of Interest		
3.	To receive the EPR Scrutiny Committee minutes of the meeting held on Wednesday 25th January 2023	*(enclosed)*	
4.	To receive the report of the EPR Implementation and Benefits Realisation Programme Board	*(enclosed)*	*Julia Bridgewater*
5.	To receive the final Deloitte Assurance Review	*(enclosed)*	*Frances Cousins*
6.	To review initial management response on the final Deloitte Assurance Review	*(enclosed)*	*Julia Bridgwater*
7.	To discuss future external assurance	*(verbal)*	*Julia Bridgwater*
8.	To consider the EPR Scrutiny Committee work programme (inc. key areas of focus and future progress)	*(enclosed)*	*Gaurav Batra*
9.	To receive, review and approve the EPR Scrutiny Committee Terms of Reference	*(enclosed)*	*Nick Gomm*
10.	Any other business		
11.	The date of the next meeting is to be confirmed.		

Audit Committee
Highlight Report

This report includes the key escalations and discussion points from the last meeting of the Audit Committee for consideration by the Board. The agenda for the meeting is included.

Committee meeting date	20th June 2023
Committee Chair	Nic Gower

KEY ESCALATION AND DISCUSSION POINTS

ALERT

n/a

ASSURE

Three internal audit reports were presented covering the Board Assurance Framework, Data Security and Protection toolkit, and Falls: prevention, assessment, and management processes.
Reports regarding tenders waived during the reporting period, and losses and special payments, were noted by the committee.

ADVISE

Internal audit provided their annual report and head of internal audit opinion. No significant issues were raised.
The annual report and annual accounts were presented for approval. No significant matters were raised by external auditors at the time of the meeting. There were a small number of issues which still required resolution prior to final sign off.
There has been an over-claim of VAT recovery resulting from arrangements with NHSP. MFT raised this issue directly with HMRC and there is an accrual in the 2022/23 accounts to cover the money owed.
MFT's Counter Fraud Functional Standard Return (CFFSR) has been submitted to the NHS Counter Fraud Agency (NHSCFA) on 30th May 2023, which had achieved an overall green rating with two components amber-rated.

RISKS

Assurance was received within the internal audit reports presented to the meeting. The internal audit report concerning Falls identified some areas which require improvement and this has been noted within the BAF presented to this Board of Directors' meeting.

ACTIONS (actions required of the Board/Committee receiving this report

To note the discussions of the Audit Committee.

LEARNING

n/a

Meeting agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

AUDIT COMMITTEE

to be held on Tuesday 20th June 2023 at 8.00am
Main Boardroom, Cobbett House
Oxford Road Campus

A G E N D A

1.	Apologies for Absence		
2.	Declarations of Interest		
3.	To Receive and Approve the Minutes of the Audit Committee meeting held on 12th April 2023	*(enclosed)*	All
4.	Matters Arising		
5.	To receive the Annual Report and Head of Internal Audit Opinion 2022/2023	*(enclosed)*	Harriet Fisher (KPMG)
6.	To receive the External Audit Completion Report	*(enclosed)*	Karen Murray (Mazars)
7.	To approve MFT's:	*(enclosed)*	
	7.1 Annual Report 2022/2023	*(enclosed)*	Peter Blythin
	7.2 Annual Accounts 2022/2023		Jenny Ehrhardt
8.	To receive a report on NHSP VAT recovery	*(enclosed)*	Jenny Ehrhardt
9.	Internal Audit (KPMG)		
	9.1 To receive the Internal Audit Progress Report	*(enclosed)*	Harriet Fisher (KPMG)
	9.2 To receive the Group Assurance Model 2022/2023	*(enclosed)*	Harriet Fisher (KPMG)
10.	Local Counter Fraud Specialist (MiAA)		
	10.1 To Receive the Local Counter Fraud Specialist progress report	*(enclosed)*	Suki Pooni (Grant Thornton)
11.	To receive an update report on Atlas Diagnostics	*(enclosed)*	Simon Walsh/ Tim Keeler
12.	Items for Noting and/or Information		
	12.1 Tenders Waived for the period 1st March 2023 to 31st May 2023	*(enclosed)*	Simon Walsh
	12.2 Losses and Special Payments for 1st April 2022 to 30th April 2023	*(enclosed)*	Rachel McIlwraith
13.	To receive the Audit Committee work programme	*(enclosed)*	Nic Gower

14. Minutes from MFT Board Sub-Committees for Assurance:

    14.1 Group Risk Oversight Committee held on 20th March 2023
    14.2 Charitable Funds Committee held on 28th March 2023
    14.3 Quality & Performance Scrutiny Committee held on 18th April 2023
    14.4 HR Scrutiny Committee held on 18th April 2023
    14.5 Finance and Digital Scrutiny Committee held on 25th April 2023
    14.6 EPR Scrutiny Committee held on 26th April 2023

15. The next meeting will be held on **Wednesday 13th September 2023** at **10:00am**

Quality and Performance Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last meeting of the Quality and Performance Scrutiny Committee for consideration by the Board. The agenda for the meeting is included.

Committee meeting date	20th June
Committee Chair	Damian Riley

KEY ESCALATION AND DISCUSSION POINTS

ALERT

250 patients likely to breach 78ww target at end of June due to patient choice, unfitness for surgery and corneal grafts.
It is forecast that cancer performance is aimed to be back on plan by end of June but some challenges with remain with gynaecology.
Diagnostic waiting lists remain high.

ASSURE

Hospitals have plans in place to have zero 65ww by end of March.
The very small number of 104 week waiters are not due to capacity reasons but instead are due to patient choice or the patient being unfit for treatment.
Assurance was provided by SMH regarding achievement of Ockenden's IE4.
Learning from incidents has led to a new framework to reduce delays in the transfer of women to the neonatal unit.

ADVISE

Actions are being pursued through the Outpatient Board to transform the outpatient pathway.
The NHSE elective priorities Board checklist was agreed for approval by the Board.
The PSIRF is being implemented across the Trust but will take some time to fully embed.
An enhanced approach to never event learning was discussed and will be implemented.

RISKS

The strategic risks relevant to QPSC were presented to the Committee with positive and negative assurance received through the reports described in the 'Alert' and 'Assure' sections above.
QPSC agreed the change of the focus for the risk concerning never events to become 'optimising human system interaction'.

ACTIONS (actions required of the Board)

To note the discussions of the QPSC.

LEARNING

The committee heard recent learning in action and quality improvements in maternity services, including:
- Introduction of a "red pathway" for emergency transfer to labour ward;
- Reduction in babies needing transfer to NNU
- Improvements following the CQC visit

Learning from the CQC's inspection of maternity services that is relevant to MFT's other Hospitals / MCSs / LCOs will be shared accordingly.

Meeting agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Quality & Performance Scrutiny Committee
Tuesday 20th June 2023 at 2.00pm
MAIN BOARDOOM, COBBETT HOUSE

A G E N D A

1.	Apologies		
2.	Declarations of Interest		
3.	Minutes of the Quality & Performance Scrutiny Committee held on Tuesday 18th April 2023	*(enclosed)*	*All*
4.	Matters Arising if not on the main agenda		
5.	**Performance Items for Scrutiny and Assurance:**		
5.1	MFT performance against operational performance metrics within the Integrated Performance Report and the AOF	*(enclosed)*	*Lorraine Cliff*
5.2	NHSE elective priorities 2023/24: Board checklist	*(enclosed)*	*Lorraine Cliff*
5.3	Updates on strategic risks relevant to operational performance including escalations from GROC	*(enclosed)*	*Tanya Claridge*
6.	**Quality/Safety items for Scrutiny and Assurance:**		
6.1	MFT performance against Quality and Safety metrics within the Integrated Performance Report	*(enclosed)*	*Cheryl Lenney*
6.2	To receive a progress report on the Patient Safety Incident Response Framework	*(enclosed)*	*Toli Onon*
6.3	To receive a report on learning from 'Never Events' during 2022/23	*(enclosed)*	*Toli Onon*
6.4	Maternity:		
	6.4.1 To receive the Ockenden Immediate and Essential Action (IEA) update	*(presentation)*	*Kathy Murphy/ Alison Haughton*
	6.4.2 To receive a staff story from Saint Mary's on learning from serious incidents and the continued progress relating to the Immediate and Essential Action (IEAs) in the Ockenden report	*(enclosed)*	*Kathy Murphy/ Alison Haughton*
6.5	Update on strategic risks relevant to quality and safety including escalations from GROC	*(enclosed)*	*Cheryl Lenney / Toli Onon*
7.	To review the QPSC Work Programme	*(enclosed)*	*Damian Riley*
8.	To note the following Committees held meetings:		
	8.1 Group Risk Management Committee held on 20th March 2023	*(enclosed)*	
	8.2 Quality and Safety Committee held on 16th February 2023 and 20th April 2023	*(enclosed)*	
	8.3 Operational Excellence Board for the period May 2023 – June 2023	(enclosed)	
9.	The next meeting will take place on Tuesday 29th August 2023 at 1:00pm		

Workforce Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last Committee meeting of the Workforce Scrutiny Committee for consideration by the Board of Directors. The agenda for the meeting is included.

Committee meeting date	20th June 2023
Committee Chair	Angela Adimora

KEY ESCALATION AND DISCUSSION POINTS
ALERT
n/a
ASSURE
The latest workforce metrics within the Integrated Performance Report were discussed, providing both negative and positive assurance. Industrial action was managed well by the hospitals/MCSs/LCOs. More junior doctors attended than previous periods of industrial action. Higher levels of elective activity were achieved as a result of this. A programme of work is underway to encourage veterans to work for MFT and to support them in their roles. Th Guardian of Safe Working report was received and discussed. Q4 Freedom to speak up quarterly report was discussed. The cluster of issues at MRI reported in the last report has been acted upon by the Guardian in partnership with MRI's SLT. Work undergoing to address issues raised in the staff survey, fronted up by Mark. All h/m/l management teams supportive. Update of the delivery of the Diversity Matters strategy was presented, Band 7 BAME representation is above target at present but there is still work to do within other pay ranges. 23000 queries have been received by the new workforce call centre since February with 97% resolved. The committee received a BAF + report focusing on employee relations and the range of controls and sources of assurance in place. An update on the wide range of EHW services in place for staff was received. MFT overall compliance score for non-medical appraisals is 81.4% against a target of 90% in April 2023. Medical appraisals are up to >90% across all groups - additional work is underway to target the 32 doctors who are non- compliant without good reason
ADVISE
A MFT Senior Leaders' event will be held on 29th September. Absence rates are improving overall but there are still some areas of the organisation which have high rates. Lime Arts will be carrying out some joint work with the Royal Northern College of music and are having their 50 year anniversary event on 19th/20th July. The WRES/WDES data is two years old and new data is currently being collected. A Digital maturity assessment and development programme is taking place across the Trust. The People Plan delivery report was considered by the committee. There is further junior doctors industrial action planned for June. Consultants and radiographers are also voting on whether to undertake industrial action which is also likely to take place in June.
RISKS
The strategic risks relevant to WFC were presented to the Committee with assurance received through the reports described in the 'Assure' section above.
ACTIONS (actions required of the Board/Committee receiving this report
To ensure that Board level discussion of the IPR in an integrated way, ensuring triangulation of issues across the four areas covered.
LEARNING
n/a

Meeting agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Workforce Scrutiny Committee

Tuesday, 20th June 2023 at 11.00am – 1.00pm
A G E N D A
Main Boardroom, near Cobbett House Reception, ORC

1.	Apologies		
2.	Staff Story		
3.	Declarations of Interest		
4.	Minutes of the Workforce (formerly HR) Scrutiny Committee held on 18th April 2023	*(enclosed)*	*All*
5.	Matters Arising (if not included on the Main Agenda)		*All*
6.	MFT performance against workforce metrics included in the Integrated Performance Report	*(enclosed)*	*Peter Blythin*
7.	Report of the Group Executive Director of Workforce and Corporate Business	*(enclosed)*	*Peter Blythin*
8.	Guardian of Safe Working Quarterly Report (Q4)	*(attached)*	*Toli Onon*
9.	To receive the Annual Report of the Freedom to Speak-Up Guardian (including Q4 data) 2022/23	*(enclosed)*	*Nick Bailey*
10.	To receive a progress report on the Staff Survey Improvement Plan/Initiatives	*(enclosed)*	*Peter Blythin*
11.	To receive a progress report on Diversity Matters	*(enclosed)*	*Nick Bailey*
12.	To receive a report on staff appraisals including correlation factors between compliance and work performance	*(enclosed)*	*Peter Blythin*
13.	To receive an update report on the MFT's People Plan	*(enclosed)*	*Claire Macconnell*
14.	To receive an update on the Workforce Digital Strategy 6-monthly Progress Report	*(enclosed)*	*Claire Macconnell*
15.	To receive the 'Workforce BAF Plus' Dashboard	*(enclosed)*	*Claire Macconnell*
16.	To receive a report on Employee Health and Wellbeing	*(enclosed)*	*Nick Bailey*
17.	Updates on strategic risks relevant to workforce including escalations from GROC	*(enclosed)*	*Peter Blythin*
18.	To receive the Workforce Scrutiny Committee work programme	*(enclosed)*	*Committee Chair (Angela Adimora)*
19.	To note the following meetings held:		
	19.1 Workforce & Education Committee meetings held on 28th April and 26th May 2023	*(enclosed)*	*Committee Chair (Angela Adimora)*
	19.2 Medical Directors' Workforce Board meeting held on 20th April 2023 and 25th May 2023	*(enclosed)*	*Committee Chair (Angela Adimora)*
20.	Any Other Business		*All*

21. The next meeting is to be held on **Tuesday, 29th August 2023 at 10:00am in the Main Boardroom, ORC**

Finance and Digital Scrutiny Committee
Highlight Report

This report includes the key escalations and discussion points from the last meeting of the Finance and Digital Scrutiny Committee for consideration by the Board. The agenda for the meeting is included.

Committee meeting date	27th June 2023
Committee Chair	Trevor Rees

KEY ESCALATION AND DISCUSSION POINTS

ALERT

The year to date (YTD) position for the Trust is a £21.7m deficit against a planned deficit of £16.9m.
YTD pay expenditure is overspent by £15.4m, YTD non-pay expenditure is below plan by £9.0m.
The YTD cash balance is £169.5m which is below forecast by £4.1m.

ASSURE

Year to date income is overall £0.9m better than plan.
The month 2 forecast position is breakeven assuming 100% delivery of the Waste Reduction Programme (WRP.
67.2% of the overall WRP target has been met and work is ongoing to improve this position with external support being procured to identify WRP opportunities and to support implementation.
Work is continuing to ensure the IG mandatory training compliance target of 95% is met by the deadline.
Wi Fi infrastructure issues remain a focus and some issues have been resolved.
Robust protocols are in place to respond to any impactful phishing incident which occurs. These include 24- hour support from national teams.
The RTT data validation exercise is proving successful with a 13% clock stop rate following validation.

ADVISE

Informatics-led Clinical Walkrounds and Technical visits are taking place across MFT to identify any digital issues which could be resolved to improve staff experience and patient care.
The National Cost Collection Exercise has provided useful data suggesting that there are opportunities across MFT to further reduce the cost of care.

RISKS

The strategic risks relevant to FDSC were presented to the Committee with positive and negative assurance received through the reports described in the ‘Alert’ and ‘Assure’ sections above.

ACTIONS (actions required of the Board)

To note the discussions of the FDSC.

LEARNING

Lessons learned from the national cost collection exercise will be shared as they emerge.
Successful WRP initiatives are being shared between Hospitals/MCSs/LCOs.

Meeting agenda

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Finance & Digital Scrutiny Committee

Tuesday 27th June 2023 at 2.00pm – 4:00pm

MAIN BOARDROOM, COBBETT HOUSE

A G E N D A

1.	Apologies		
2.	Minutes of the Finance & Digital Scrutiny Committee Meeting held on 25th April 2023	*(enclosed)*	*Trevor Rees*
3.	Matters Arising	*(enclosed)*	*Trevor Rees*
4.	Chief Finance Officer's Report M2	*(enclosed)*	*Jenny Ehrhardt*
5.	Chief Information Officer's Report	*(enclosed)*	*Dan Prescott*
6.	Waste Reduction Programme - Update	*(enclosed)*	*Tim Barlow*
7.	2021/2022 National Cost Collection Report	*(enclosed)*	*Jenny Ehrhardt/ Amanda Brooks*
8.	MFT performance against Finance metrics within the Integrated Performance Report	*(presentation)*	*Jenny Ehrhardt*
9.	Update on strategic risks relevant to the FDSC including escalations from GROC	*(enclosed)*	*Jenny Ehrhardt/ Dan Prescott*
10.	To receive the FDSC work programme	*(enclosed)*	*Trevor Rees*
11.	The next meeting will be held on **Wednesday 23rd August 2023 at 10:00am**		

Agenda Item 9.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Directors
Paper prepared by:	Tanya Claridge, Acting Director of Clinical Governance
Date of paper:	July 2023
Subject:	Integrated Performance Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The report details progress in meeting performance targets which are key to the delivery of the Trust's strategic aims.
Recommendations:	The Board of Directors is asked to note the content of the report.
Contact:	Name: Nick Gomm, Director of Corporate Business / Trust Board Secretary Tel: 0161 276 4841

Manchester University
NHS Foundation Trust

Integrated Performance Report

Reporting period to 31st May 2023

Introduction

The report provides the Board with an integrated focus on key performance indicators relating to quality and safety, operational performance, workforce and finance. The report is designed to enable the Board to have oversight of a range of metrics (including those monitored through the national contract and those locally derived) in the context of insight and assurance in relation to the:

- effectiveness of the controls and enablers in place to ensure improvement in the quality of care and operational efficiency aligned to the Trust's Strategic Aims, it is a key source of assurance to support the Board Assurance Framework.
- compliance with CQC fundamental standards across all the domains of quality and safety
    - Safe: patients, staff and the public are protected from abuse and avoidable harm.
    - Effective: care, treatment and support achieves good outcomes, helping people maintain quality of life and is based on the best available evidence.
    - Caring: staff involve and treat everyone with compassion, kindness, dignity and respect.
    - Responsive: services are organised so that they meet people's needs.
    - Well-led: the leadership, management and governance of the organisation make sure it's providing high-quality care that's based around individual needs, that it encourages learning and innovation, and that it promotes an open and fair culture.
- core principles contained in the NHS Constitution of:
    - Equality of treatment and access to services
    - High standards of excellence and professionalism
    - Service user preferences
    - Cross community working
    - Best Value
    - Accountability through local influence and scrutiny

The Board's consideration will be supported by exception reports from relevant Scrutiny Committees , who routinely scrutinize the assurance and mitigation of risk in relation to the metrics where an area of performance is giving rise for concern, or where a significant improvement has been achieved.

Integrated Performance Report Navigation Panel

Delivering our Strategic Aims

Our Strategic aims	Our enablers 2023/24																
	Quality and Safety Strategy 2022/25	Patient Safety Plan 2023/24	Effectiveness Plan 2023/24	High Priority Audit Plan	What Matters to me	Mental Health Strategy	End of life care strategy	Urgent and Emergency Care Strategy	Inequalities strategy	Financial plan	Operational Plan 23/24	People Plan					
To focus relentlessly on improving access, safety, clinical quality and outcomes	●	●	●	●	●	●	●	●	●		●						
To improve continuously the experience of patients, carers and their families	●				●	●	●		●		●						
To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best	●										●	●					
To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future											●	●					
To use our scale and scope to develop excellent integrated services and leading specialist services											●						
To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve											●						
To achieve and maintain financial sustainability										●	●						
To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda	●	●	●	●	●		●		●		●						

Understanding our performance

We use the objectives within our key enablers (our strategies and plans) to help us identify measures of success. Our measures of success are metrics (qualitative and quantitative) that are designed to help us make better decisions about how to improve services and to help us identify and monitor the effectiveness of our response to risks to the delivery of our strategic aims. We use this data to

- Provide measurable results to demonstrate progress towards outcomes
- Identify areas needing attention and opportunities for improvement
- Support continuous improvement.

Our measures of success will include

- System-level measures of community wellbeing and population health including reductions in avoidable deaths for treatable conditions, improved mental health and
- Trust level proxies for improved health outcomes such as avoidable admissions to hospitals, lengths of hospital stay, and patient safety
- Personal health outcomes to our patients, primarily relating to measures of responsiveness
- Resource utilisation
- Organisational processes and characteristics that support evidence that systems to support high-quality people centred care
- Patient and carer experiences of, for example, shared decision-making, care planning, communication and information sharing, and care co-ordination.

How we understand our performance and escalate any risks identified

Measuring our Performance

We, where possible and appropriate, use the identification of Special Cause Variation in our data to understand our performance. We use four specific tests in our data to look for unexpected variation in our Statistical Process Control Charts. Where SPC charts are not deemed the most appropriate use of data, alternative charts and display mechanisms have been included. It is important to note that whilst the variation and assurance symbols are predominantly associated with SPC charts, we have taken the approach of standardising their use within this document across all data types to ensure consistency of language and approach. Also included, where benchmarking data is available (for instance through national or locally derived standards) an indication of compliance with those standards. A summary of the action status is also provided aligned to each indicator.

The table below provides a summary of the symbols used within this integrated performance report.

Compliance

Target being met	
Target not met	
For information, no target set or target not due	

Variation

Common cause – no significant change	
Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	
Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	

Assurance

Variation indicates Inconsistently passing and falling short of the target	
Variation indicates consistently (P)assing the target	
Variation indicates Consistently (F)alling short of the target	

Action Status

Active surveillance – continue to observe in order to better understand the current position	
Improvement – continue actions to support improvement until steady state achieved	
Deterioration or maintained underperformance – instigate or review actions to ensure drivers of current position are mitigated	
Steady state – continue to monitor achievement of level of performance which is satisfactory, and which requires no intervention to maintain	

Escalating performance concerns

Using the four SPC rules and outcomes of our benchmarking , we use an Alert, Advise and Assure model to ensure that both risks and improvements associated with performance are escalated appropriately using the Trust's risk escalation framework, through the Trust's Governance Infrastructure. Risks identified through the assessment of and assurance associated with any element of performance that may have an impact on the delivery of the Trust's Strategic Objectives are reflected within the Trust's Board Assurance framework.

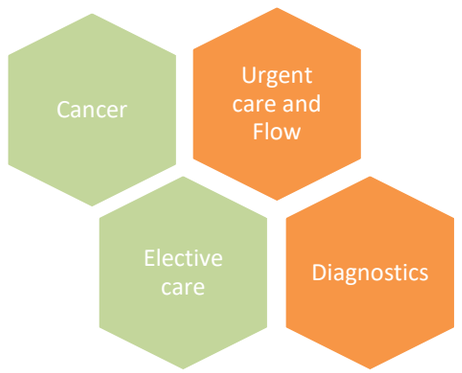
Alert	Advise	Assure

Integrated Performance Report Overview

Quality and Safety

There are a number of elements of the Trust's safety profile under additional scrutiny by the QPSC, these include the safety and reliability of surgical and invasive procedures (subject to an exception report at the recent meeting) and maternity safety and associated compliance with regulatory standards. An extra-ordinary meeting of the QPSC was held to support the detailed scrutiny of assurance (both local, oversight and independent) related to the response of the service to the CQC warning Notice received in March 23 following an inspection.

Operational Performance



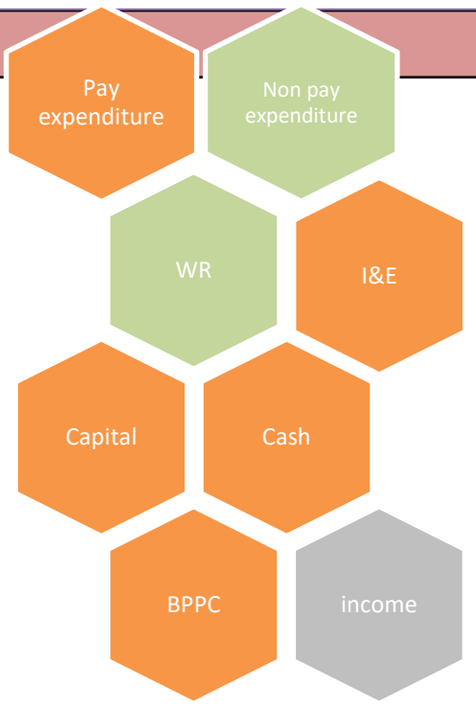
Good progress is being made in a number of areas of operational performance, with areas of escalation considered by the QPSC specifically in relation to diagnostic performance and in relation to performance associated with no clinical reason to reside. Both areas are reflected in the relevant strategic risks. The QPSC has requested detailed scrutiny of the assurance associated key delivery workstreams during the course of its next meetings to focus on sustainability of actions and the risks associated with compliance with national targets

Workforce

Good progress is being made in the delivery of the MFT People Plan and the Diversity Matters Strategy. Action plans are in place to respond to the results of the most recent NHS staff survey. Compliance with medical appraisals has shown good progress whilst work is still required on increasing compliance with non-medical appraisals. Periods of industrial action have been well managed so far with planning underway for the industrial action planned in July.

Finance

The Trust's financial position remains under close scrutiny by the FDSC. This includes monitoring of delivery of the Trust's Waste Reduction Programme (WRP) for 2023/24 as the Trust's breakeven forecast is dependent on 100% achievement of the WRP. The overall financial position is currently showing a deficit against plan. Year to date income is currently above plan. Year to date pay expenditure is currently overspent but non-pay expenditure is below plan. The Trust's cash position is currently below plan.



Quality and Safety Report

Quality and Safety: Patient Safety Executive Summary

Key Performance Metric

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Oversight	S1					Serious Incidents Requiring Investigation (reported in Month) per 1,000 occupied bed days	local
	S2					Never Events	National
	S3					Notifiable patient safety incidents: Non-notifiable incidents (ratio)	Local
System reliability	S4					National patient safety alerts over deadline	National
	S5					Surgical Safety Checklist compliance	Local
	S6					LocSSIP Compliance	Local
	S7					Attributable Reportable organism infections	National
	S8					Maternity dashboard indicators alerting	New
	S8					Compliance with patient specific assessments	New
	S9					Safety profiles alerting	Local
PSIRP 23/24	S10					Patients waiting for access to care who experience associated harm	Local
	S11					Notifiable incidents related to surgical procedures	Local
	S12					Notifiable incidents related to invasive procedures	Local
	S13					Notifiable incidents related to a patient with a mental health concern	Local
	S14					Notifiable incidents related to medication safety	Local
	S15					Notifiable incidents related to Ergonomic design	Local
	S16					Notifiable incidents related to Discharge	Local
	S17					Notifiable incidents related to the effective assessment and management of risk (Falls etc)	Local
Learning and culture	S18					Prevention of future deaths notifications	Local
	S19					% patient safety risks not mitigated exceeding the deadline for mitigation	New
	S20					Culture: People Promise: We each have a voice that counts (staff survey 2022)	National

Joint Group Medical Directors' and Chief Nurse's Summary

The Trust has a Safety Oversight System that operates daily throughout the Trust, providing contemporaneous scrutiny and contextualisation of quality and safety intelligence. This enables immediate action in relation to emergent risk, for instance through the issuing of Trust wide patient safety alerts, but also the identification of high impact and transferable learning. In April 2023, the Group Quality and Safety Committee approved the Trust's Patient Safety Plan, designed to provide the infrastructure for the implementation of the Patient Safety Incident Response Framework and describing the clear focus for patient safety improvement that will be included in the Trust-wide Patient Safety Incident Response Plan when published in September 2023

The key areas of focused improvement and assurance in relation to patient safety are aligned to the patient safety insight, involvement and improvement priorities identified for 2022-23 in the Patient Safety Plan and include the controls associated with the safety of invasive procedures, medicines safety, effective management of patient risk, patients waiting for access to care, diagnostics and/or treatment, maternity safety and understanding the impact of inequality

All of the above areas are subject to exception reporting for additional scrutiny through the Quality Governance infrastructure of the Trust.

Using historic Trust data as a benchmark, the Trust's rolling 12 month never event profile continues to give rise to concern: with a particular area of focus on invasive procedures. The QPSC received an exception report in relation to the focus of safety improvement work, this was also described at GROC in relation to the strategic risk exposure.

The Board of Directors receives routine reports relating to Maternity services, and the QPSC has held an extra-ordinary meeting to scrutinize the SMMCS response to the CQC warning notice. The areas of escalation from the dashboard are currently under detailed review.

The Trust has two overdue National Patient Safety Alerts and one alert where compliance was changed following the implementation of Hive (all medicines related). The alerts are subject to a risk assessment and progress with compliance is being managed through the Medicines Safety Committee.

The Group Infection Control Committee oversees the performance associated with attributable reportable organism performance, with a key focus on screening compliance, timeliness of decolonisation therapy, anti microbial stewardship, ability to isolate (environmental factors). And adherence to IPC pathways.

The safety profile relating to urgent and emergency care is alerting, and the mitigation of associated risks for waiting patients is described in the strategic risks 6352 and 6469. This profile has been received for scrutiny by the QPSC (April 23).

The Trust was issued with a PFD relating to the role and responsibilities of Physician Associates, specifically in relation to discharge. The Trust will be providing the necessary assurance in response.

Further areas of focus where there were opportunities to strengthen patient safety controls include:governance associated with safety critical procedural documents, patient safety culture and the effective governance of the management of risk

Risk Profile

Group Wide Risk Profile

No.	Strategic Risks	Risk Score
1150	Controlled drug storage	16
5182	Human System interaction	20
6352	Clinical Harm-waiting patients	15
5480	HIVE impact on patient safety	12

Quality and Safety: Effectiveness Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation/ data	Assurance	Action status	Indicator	Indicator Type
Outcomes	E1					Hospital Standardised Mortality Ratio (HSMR)Rolling 12mth	National
	E2					Hospital Standardised Mortality Ratio	
	E3					Hospital Standardised Mortality Ratio (HSMR) Crude Mortality (Trust)	National
	E4					Summary Hospital-Level Mortality Indicator (SHMI) QUARTERLY	National
	E5					% of deaths screened	National:
	E6					Structured Judgement Reviews resulting in a Hogan Score of 3 or below	Local
	E7					National audits: Outlier status	National
	E8					National Audits (CQC Profile) recording outcome worse than expected	Regulator: No data
	E9					Local Audits –limited assurance	
	E10					30 day readmission rate	Local
	E11					% NICE Guidance: Evidence of implementation	Local
	E12					% policy and clinical guidance in date	Local
	E13					National Audit case ascertainment	Local
	E14					% high priority local audits discontinued	Local
	E15					CQUIN 1: Flu vaccinations for frontline healthcare workers	CQUIN (prioritised)
	E16					CQUIN 2:Supporting patients to drink, eat and mobilise after surgery	CQUIN (prioritised)
	E17					CQUIN 3: Timely communication of Medicines changes to community pharmacists	CQUIN (prioritised)
	E18					CQUIN 4:Prompt switching of intravenous (IV) antimicrobial treatment	CQUIN (prioritised)
	E19					CQUIN 5: Identification and response to frailty in emergency departments	CQUIN (prioritised)
	E20					CQUIN Composite (all other indicators	CQUIN (prioritised)

Joint Group Medical Directors' Summary

The Quality and Safety Strategy 2022-25 has acted as an enabler for the Trust to review its performance within the Effectiveness domain with a different lens than previously. The focus on insight as led to the initiation of a programme of work to identify the correct, proportionate and relevant metrics to measure progress to achieving the objectives identified in the Effectiveness plan. The metrics presented in the current version of the IPR are traditional and focus on mortality, the management of external recommendations, the key controls in place (clinical policies and guidance), performance in national audit and the national CQUIN scheme.

Utilising data from Hive and also in an aggregated and benchmarked format in the Healthcare Evaluation Data (HED) the indicators are currently under review to support a more integrated approach to outcome data, with a clear focus on understanding and eliminating unwarranted variation.

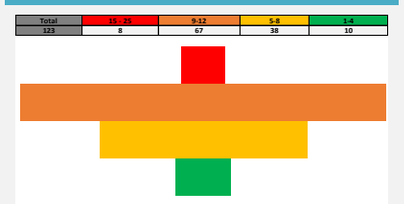
There are several important areas for escalation from the data available:
There is a continued risk that assurance in relation to implementation of NICE guidance across the Trust has been sub-optimal. A revised process has now been put in place to provide ongoing assurance in relation to newly published or revised NICE guidance. There is a requirement to complete an assurance exercise in relation to previously published guidance, which has now been commenced. This is being monitored through the Clinical Effectiveness Committee with escalations to the Clinical Practice Oversight Committee.
There is evidence that there has bee sub-optimal compliance with the Trust's High Priority Audit Plan 22/23
There is a potential issue in relation to case ascertainment and data validation within the national audits
There is also a risk in relation to policy governance across the Trust, with the governance of a significant number of policies sub-optimal. This position has been escalated to the Quality and Safety Committee and is a weakness in control in strategic risks and as such escalated to the Group Risk Oversight Committee. This issue is compounded by a policy management solution that is not easy to navigate. There is an action plan in place to address the policy governance backlog, and a plan to procure a policy management system that better meets the needs of the Trust.

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain quality of services	2	15

Risk Profile

Group Wide Risk Profile



No.	Strategic Risks	Risk Score
6352	Clinical Harm-waiting patients	15
5480	HIVE impact on patient safety	15

Quality and Safety: Caring Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Oversight						Friends and Family test (response rate)	Local
						What Matters to Me (Overall Score)	Local
						Mixed sex accommodation breaches	National
						Upheld complaints (rate)	Local
						Formal Complaints received	Local
						Re-opened complaints (rate)	Local
						Ombudsman referred complaints	Local
Learning and Culture						National Adult Inpatient Survey (2021): Composite metric	Local
						Excellence / Compliments Received	Local
						Innovation	Local
						Improvement Priorities	Local
						National Children and Young People's Inpatient and Day Case Survey (2020) Composite metric	Local
						Urgent and emergency care survey 2020; Composite metric	Local
						National Maternity Survey (2022): Composite metric	Local

Risk Profile

Profiling technique under development

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain quality of services	16	20

Chief Nurse's Summary

During May 2023, MFT has seen a slight increase in the number of **complaints that were upheld.** An initial review of the themes has identified that communication at the point of care delivery is the main reason that the complaint was upheld. Further analysis is being led by the Patient Experience Team to identify specific learning and inform action planning, which will be monitored through the Patient Experience Forum.

There has been a slight increase in the number of **formal complaints** received, the themes in May are concerns raised about Treatment / Procedure and further analysis is taking place through June 2023 to drill down further to identify trends and ensure they are aligned to targeted improvement plans.

An improvement has been noted in **complaints re-opened,** where the rate has decreased from 20.7% in April to 15.59% in May. A complainant may be dissatisfied with our response for a number of reasons; a key theme in May has been noted that we did not respond or resolve all the concerns they raised through our complaint response letter. The Patient Experience Team are leading focussed training (quality of response and investigation) to further reduce the rate at which complaints are re-opened, but more importantly to ensure that when concerns are raised there is good resolution and learning that can be spread across all sites.

The **Family and Friends Test** response rate is monitored, as is the % of those who would recommend our services. During May we received a total of 14,788 responses, 92.74% rated our services as good, and 4.42% rated services as poor. Feedback is provided directly to clinical areas, there is no special cause variation noted. Maternity Services utilise Maternity Voices Partnership (MVP) feedback in addition to Friends and Family (where women do not tend to engage with FFT), and during May have seen improvement in feedback from patients either through MVP, or through QR codes introduced in May, readily accessible in in-patient areas. In the LCO, FFT is also utilised less due to the nature of services delivered in people's homes. The LCO have introduced QR codes that can be accessed in homes and clinics. Analysis of themes and learning will be monitored through the Patient Experience Forum. Active surveillance also includes What Maters to Me (WMTM) and Quality Care Round (QCR).

Mixed Sex accommodation breaches have occurred in critical care areas, where exemptions are in place that support delivery of single sex critical care services in mixed sex environments. At the point of discharge, the exemption is no longer applicable and a 'breach' is said to occur if we have been unable to discharge a patient to a step-down area. The Patient Experience Forum are monitoring this, aiming to work with the critical care teams to identify any earlier drivers of the target not being met, for instance earlier communication of potential breach, in order to improve.

There has been a significant positive increase in the number of **What Matters to Me** (WMTM survey completions since October 2022 and March 2023, however, there is a slight decrease in April 2023 with 3507 responses compared to 3954 in March 2023. The Patient Experience and Quality Improvement Teams have identified food provision as a focussed area, which has also been noted through Clinical Accreditation, with a refresh of mealtime processes being undertaken. May data is not available at the time of reporting.

Whilst **formal compliments** are recorded through our electronic reporting systems, informal compliments are not routinely collected. Ways in which informal compliments can be captured across all hospitals/MCS/LCO is being considered for inclusion in future reports.

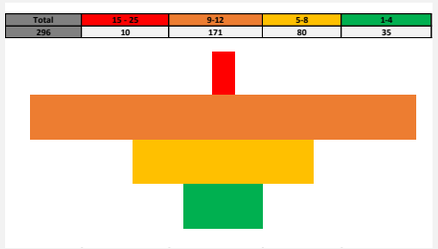
The results of the **National In-Patient and Maternity Surveys** are currently being analysed.

Quality and Safety: Responsiveness Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Oversight						Deaths with a Hogan score of <3 (Protected characteristics)	Local
						NI/Red complaint Protected characteristics	Local
		⊗	H	F	⊗	NI/Red complaint: Discharge/transfer	Local
		⊗	L	F	⊗	Duty of Candour compliance	Statutory
System Reliability						7DS compliance	National
						Accessible Information standard compliance	Local
		ⓘ	~	H	⇄	Clinical Accreditation	Local
		ⓘ	~	H	⇄	PLACE Outcomes	National
		⊗	H	F	⊗	Access to timely care/assessment and treatment	National
						% ReSPECT forms reviewed at each encounter	Local
Mental Health Strategy		ⓘ	~	H	◎	Mental Health Act 1983 (MHA) compliance: Section 132: % Provision of information to patients	Local
		ⓘ				Mental health training compliance	Local
		ⓘ				NI/Red Complaint (Mental health concern)	Local
		ⓘ				Mental health in acute Trusts: Quality standard compliance	Local
		ⓘ				Deprivation of Liberty	
LD Strategy						% of people with a Learning disability or who are autistic who have evidence of reasonable adjustments in place	Local

Risk Profile



No.	Strategic Risks	Risk Score
6469	Urgent & Emergency Care – ED & Patient Flow	16
6470	Scheduled Care Inpatient and Outpatient Backlog	16
6475	Cancer Pathway Delays	12
6467	Diagnosis Delay – patients >6 weeks from referral to diagnostic test	15

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain quality of services	16	20

Joint Group Medical Directors' and Chief Nurse's Summary

The responsiveness metrics are new indicators and are being developed. Through the Quality Governance structures in place, there is surveillance and oversight in place of the indicators agreed.

We have noted special cause variation in **complaints related to discharge or transfer** from hospital. We aim to have a collective shared view of data, and a series of focussed work is underway including, a high-level learning event held with key stakeholders (pharmacy, palliative care, community and discharge teams) has been held with a mapping exercise taking place to identify workstreams. Importantly, the LCOs Resilient Discharge Programme as a key piece of work to ensure the patient voice is understood at the point of discharge, and to assure sustainability of improvements made, via social care as part of pilot evaluation (due January 2024), to understand the patient voice at the point of discharge.

Duty of Candour compliance is an area of signifincat development aligned to the implementation of the PSIRF, with a revise policy and training opportunities in place. The risk in relation to this area of patient engagement is recognised across the Trust with each Site/MCS/LCO proactively mitigating the risk through enhanced monitoring and dedicating specific staff for enhanced oversight..

The 2023/24 **Clinical Accreditation** programme, refreshed in February 2023, commenced in April 2023, with 28 accreditations already undertaken, including reassessment of three areas identified as 'white' (lowest achievement). Improvement was noted in these three areas, with each now accredited as 'bronze'. The Programme has been aligned to outcomes available in the Hive system. The Annual Clinical Accreditation Report is being received at the Board of Directors meeting in July 2023.

There is special cause variation of **access to timely care/assessment and treatment**, a series of deep dives in urgent & emergency care, elective care, cancer and diagnostics have taken place in May 2023.

The **PLACE** outcomes in this report are from latest available data (October 2022). Whilst most areas score highly, variation has been noted in three areas at MRI; food, privacy and dignity. At the MLCO in-patient settings, access has been noted as requiring improvement. The Patient Experience of Care Group are monitoring the actions put in place to address the issues found. A series of PLACE 'light' visits are taking place through May and June when outcomes will be shared in future reports.

Compliance with **s132 of the Mental Health Act 1983** has been monitored since January 2023 following an initial review of Mental Health provision undertaken by the Trust Safeguarding Team. The main area of concern relates to bed availability and being able to effectively provide and record the correct information to patients in a timely manner.

There were no **red complaints or incidents relating to Mental Health Concerns** in May 2023.

There is oversight of a range of safeguarding indicators through the Group Safeguarding Committee and the AOF, however new indicators, such as compliance with **Deprivation of Liberty Standards, and Learning Disability / Autism and Quality Standard Compliance** are under development and will be included in the next report.

Operational Performance Report

Operational Performance: Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Compliance	Variation	Assurance	Action status	Indicator	Indicator Type
Urgent care and Flow		✗	H	?	✓	A&E 4 hour standard	National
		✗	H	?	✓	Ambulance handover within 15 mins	National
		✗	L	F	✓	Ambulance handovers over 60 mins	National
		i	L		✓	Hours lost in month due to delayed handovers	Regional
		✗	L	F	✓	Average AED arrival to triage	National
		i	L		✓	Average time to treatment (mins)	National
		✗	L	F	✓	Number of A&E DTA waits ≥ 12 hours	National
		✗	H	?	✗	No clinical reason to reside	National
Cancer		✗	L	?	✓	62 day cancer backlog	National
		i	L		👁	Cancer total PTL size	National
		✗	H	F	✓	2 Week wait overall performance	National
		✗	H	F	✓	Faster Diagnosis Standard	National
Elective		i	H		👁	RTT total list size	National
		✗	L	?	✓	RTT>78 week waiters	National
Diagnostics		✗	H	F	✗	Diagnostics (DM01) waiting list	National
		✗	H	F	✗	Diagnostics waiters over 6 weeks	National

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain operational performance	4	16

Risk Profile

Group Wide Risk Profile

No.	Strategic Risks	Risk Score
6469	Urgent & Emergency Care – ED & Patient Flow	16
6470	Scheduled Care Inpatient and Outpatient Backlog	16
6475	Cancer Pathway Delays	12
6467	Diagnosis Delay – patients >6 weeks from referral to diagnostic test	15

Chief Operating Officer's Summary

MFT has seen a **stepped improvement in % 4 hour** performance since April 2023. Through the winter period performance was circa 50-60%. In April this increased to 72.3% with the end of May position being at 74.4%. Type 1 performance was 43.3% at the end of 22/23 and in April this was at 58.7% and at the end of May was 60.8%. The increase in % 4 hour performance has corresponded with a **positive improvement in Ambulance Handover** and a reduction in the number of patients waiting longer than 12 hours in the department The numbers of patients on our no reason to reside continues to be stubbornly high averaging 320 against a target of 240. Our most challenged site remains the MRI, that whilst there has been an improvement, this is still some way from the standard expected. Comparing to regional and national providers, **MFT is now 47th out of 129 nationally** and 19 out of 46 across the region. The national recovery plan sets out an ambition to deliver as a minimum 76% performance against the 4hr standards and MFT are committed to exceeding this. GM have been placed in TEIR1 for Urgent Care of which MFTs performance plays a significant part across GM with a visit and support by the National Team being planned specifically focusing on the MRI.

MFT remains committed to reducing the number of patients waiting **78 weeks** to virtually zero by June 2023 and **65 weeks** by March 2024. The long wait position for May ended 1372 actual 78ww breaches including 4 patients over 104 weeks due to choice and medically unfit. The forecast for end of June is indicating 191 due to patient choice, patients unfit and 23 corneal graft patients. Both 78 and 65 week cohorts continue to track ahead of the straight line trajectory.

There has been good progress made on reducing the number of **patients with suspected cancer waiting over 62 days** for treatment from its peak of 1,200 in November 22 to c.300 currently. Equally, the total waiting list for patients on suspected cancer pathways has reduced by 48% since its peak in September despite there being a 27% increase in referrals compared to previous years. Whilst performance was slightly above trajectory in May reporting 379 against a plan of 320, plans are in place to get back on track in all tumour sites by June other than Gynaecology which will be August due to consultant recruitment.

Cancer waiting times within Imaging for CT and Non Obstetric Ultrasound meeting the 10 day Turnaround times. However, Cancer waiting times for MR scans had deteriorated in April/May due to unplanned scanner down time. These are now recovering and operating at approx. 12 days, further improvement is expected in the coming weeks. **DM01 performance remains an area of challenge**. A trajectory for improvement has been developed and split by diagnostic modalities with the main areas of concern being **across Echocardiography and NOUS** due to volumes and workforce challenges. Equally, **paediatric MR scans** are reporting long waits due the requirement for theatre capacity as these are undertaken with a General Anaesthetic.

Workforce Report

Workforce: Executive Summary

Key Oversight Performance Metrics

Focus	Ref	Status	Variation	Assurance	Action status	Indicator	Indicator Type
Workforce capacity	W1					Establishment WTE	Local
	W2					Staff in Post WTE	Local
	W3					Vacancy WTE	Local
	W4					Vacancy Percentage	Local
	W5					Temporary Staffing WTE	Local
	W6					Temporary Staffing Cost	Local
Looking after our people	W7					Attendance Percentage	Local
	W8					Call Back & Return to Work Compliance %	Local
Learning and develop	W9					Level 1 Mandatory Compliance Percentage	Local
	W10					Level 2 & 3 Mandatory Compliance Percentage	Local
	W11					Appraisal – Non Medical Compliance Percentage	Local
	W12					Appraisal – Medical Compliance Percentage	Local
Belonging	W13					Staff Engagement Score	Local
	W14					*% of BME in Medical and Dental pay scales*	Local
	W15					% BME in band 8a and above roles	Local
	W16					*% BME in band 7 and below*	Local
	W17					*% Disability in Medical and Dental pay scales*	Local
	W18					*% Disability in band 8a and above roles*	Local
	W19					*% Disability in band 7 and below*	Local
Future focus	W20					*Turnover %*	Local
	W21					*Retention/Stability %*	Local

Director of Human Resource's Summary

Across GM, workforce metrics are still adversely affected by a challenging operational context. Although absence due to sickness is well below the rates witnessed during the pandemic, they have not returned to pre-Pandemic levels. As of April 23, the Trust Attendance Rate was 94.32%. The single month Attendance Rate has seen a steady improvement since December 22, however the Rolling 12 Month Sickness Absence rate has continued to increase into 23/24 and is currently at 6.33%.

Workforce turnover (12-month average) has seen a small improvement to 13.89% in April 23, however this remains above target. Stability/Retention Percentage is also showing an improvement on last month at 87.57% but is under achieving against target of 89%. Vacancy Rate is in keeping with turnover and retention trends remaining stubbornly above target throughout the last 12 months, currently at 9.44% against a target of 7.5%.

Mandatory training compliance levels are showing a general improvement over the last 6 months. Level 1 Mandatory Compliance for April 23 achieved against target at 90.07%. However, further attention is needed in relation to Level 2 & 3 Mandatory Compliance which remain below target at 78.83%.

Appraisal compliance is also showing a general improvement over the last 6 months, although it remains below target. Non-Medical Appraisal Compliance for April 23 was 81.24% against a 90% target. Medical Appraisal Compliance for April 23 was 88.83%, which is a slight decrease from March 23 when the Trust achieved against target at 90.02%.

Our key metrics in relation to the theme of 'Belonging' show a mixed picture. Key areas to improve on include our Staff Engagement score which is currently 6.4 for April 23 against a target of 6.8, and % BME staff in Band 8a and Above Roles which is currently 11.0% for April 23 which is much lower than the BME population of Greater Manchester at 23.6% (reported by Office of National Statistics).

The Workforce agenda remains a strategic priority for the Trust, particularly in relation to staff experience, engagement, and workforce productivity and efficiency. The MFT People Plan was reviewed at the start of the year to reprioritise deliverables aligned to organisational priorities and work continues to deliver against this plan and monitor its impact.

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to sustain an effective and engaged workforce	1	15

Risk Profile

Group Wide Risk Profile
Technique under development

No.	Strategic Risk	Risk Score
40 03	Staff Psychological wellbeing	15

Finance Report

Finance: Executive Summary

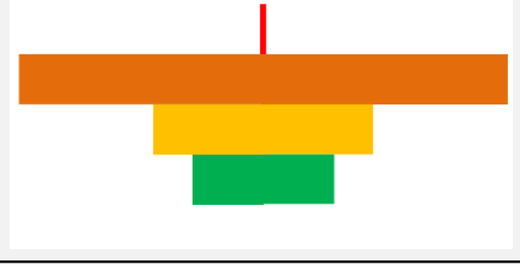
Focus	Ref	Status	Variation	Assurance	Action Status	Indicator	Indicator Type
I&E	F1	✗	L	F	✗	Financial performance against budget YTD (£'000s)	External
Pay Expenditure	F2	✗	H	F	✗	Total pay expenditure against budget YTD (%)	Internal
	F3	✗	H	F	✗	Consultant spend - variance to budget YTD (%)	Internal
	F4	✓	~	P	👁	All other Medics spend - variance to budget YTD (%)	Internal
	F5	✓	~	P	👁	Agency spend compared to total pay expenditure YTD (%)	Internal
	F6	✗	H	F	✗	Bank spend compared to total pay expenditure YTD (%)	Internal
Non Pay Expenditure	F7	✓	~	P	👁	Drugs - variance to budget YTD (£'000s)	Internal
	F8	✗	L	?	👁	Clinical Supplies - variance to budget YTD (£'000s)	Internal
Income	F9	✓	~	?	👁	Income inlcuding Elective - variance to income in finance plan (£'000s)	Internal
WRP	F10	✓	~	P	👁	WRP - variance to plan (£'000s)	Internal
Capital	F11	✗	~	?	⇄	Capital expenditure (GM plan) - variance to plan YTD (%)	Internal
	F12	✗	~	F	⇄	Capital expenditure (total plan) - variance to plan YTD (%)	Internal
Cash	F13	✗	L	F	👁	Cash balance - variance to plan in month (%)	Internal
BPPC	F14	✗	L	?	👁	Performance against Better Payment Practice Code in month (% by value)	External

Principal Risk

No.	Description	Strategic Risks	Highest scoring
3.	Failure to maintain financial sustainability	1	20

Risk Profile

Group Wide Risk Profile



No.	Strategic Risk	Risk Score
5092	Capital finance	15

Director of Finance's Summary

After two months, the year-to-date position for the Trust is a £21.7m deficit against a planned deficit of £16.9m, this is an adverse variance of £4.8m. The main reason for this adverse variance is continued material overspends on pay budgets, in part relating to last month's junior doctors' strike.

Within that YTD position the Trust delivered an in-month position for May 23 of a deficit of £8.8m against a planned deficit of £7.7m, an adverse variance of £1.1m. The key reason for this variance of £1.1m was the net amount included in the month 2 position for the impact of the pay award, moving from 2% assumed in the plan to 5%, impacting as referenced below.

Year to date income is overall £0.9m better than plan. The main drivers of this improvement are additional income relating to the revised pay award (YTD £5.3m) noting this is offset in an overspend on pay (corresponding forecast cost of £6.1m). In part offsetting this are Income for Cost Pass Through (CPT) drugs which is lower than planned (£2.9m), again for which there is an offsetting underspend in non-pay and under performance in other operating income (e.g. overseas patients and car parking income).

For Month 2 and impacting on the year-to-date position, NHSE issued reporting guidance advising Trusts to not show any assumption of over or underperformance in relation to income associated with elective activity performance, therefore all income for the planned elective activity is assumed to be received in these year to date figures. If this wasn't the case, the impact on income would be £12.3m and our therefore our reported position would be £12.3m further adverse to plan.

Year to date pay expenditure is overspent by £15.4m, £6.1m of this relates to the additional cost of the 23/24 AfC pay award (a pressure of £0.8m above expected income). c.£4m relates to the costs of covering industrial action and the remainder relates to mainly to additional medical staffing above planned levels, undelivered WRP and some budget phasing.

Year to date non-pay expenditure is below plan by £9.0m, of which £2.5m relates to CPT drugs. The balance in part relates to budget phasing and reflects the reduction in activity during the industrial action in April.

The month 2 forecast position is not available due to the timing of this report but it is anticipated at this stage in the year the Trust will deliver the planned breakeven financial position. There are some significant risks to delivery which will require mitigation.

The cash balance at 31st May was £169.5m which is below forecast by £4.1m - this primarily reflects lower than forecast cash outflows on capital (£13m) and lower payments than forecast to trade suppliers (£3m) which are offset by lower than planned income receipt for patient services (£19m). It is anticipated that the income for patient services receipt and other differences are timing issues and will be recovered and reversed in future months. Cash is lower than the planned value primarily due to timing differences. It is anticipated timing differences will mainly unwind over the next two quarters but work is ongoing to confirm assumptions and profiling.

Capital expenditure year to date against the GM envelope is £5.4m compared to a plan of £4.9m. The total capital spend year to date is £9.1m compared to a plan of £13.6m. The key driver for this underspend relates to delays to approvals for the New Hospital Programme at NMGH.

The Board will recall that the financial plan for the first 6 months of the year, against which actual results are being compared, is for a deficit each month. The second 6 months of the year requires delivery of a surplus, this is reflected in a significant shift between month 6 and 7, and in month 7 and for all months thereafter we need to deliver c£5m surplus a month. We therefore need to take steps to curtail the significant overspends in pay and reduce other areas of spend and increase progress on the identification and delivery of WRP.

Agenda Item 9.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Finance Officer
Paper prepared by:	Paul Fantini, Deputy Director of Group Financial Reporting & Planning Rachel McIlwraith, Operational Finance Director
Date of paper:	July 2023
Subject:	Financial Performance for Month 2 2023/24
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Maintaining Financial Sustainability for both the short and medium term
Recommendations:	• The Board is recommended to note the Month 2 I&E position against the 23/24 plan and Cash and Capital positions for the Trust. • The Board is requested to agree the ICB System Savings statement (focusing on cost reduction) and the allocation decisions regarding any future new funding, reproduced on page 3 and 4 of this report.
Contact:	Name: Jenny Ehrhardt, Group Chief Finance Officer Tel: 0161 276 6692

Executive Summary

1.1	**Delivery of financial plan**	The financial regime for 2023/24 continues the focus on recovery of elective activity, reduction of waiting lists that have reached historic highs across the NHS and the continued drive to prevent unnecessary hospital admissions. Added to this will be increased scrutiny on the finances of organisations as the DHSC looks to reduce overall costs of the health service and reduce underlying deficits across the NHS. Block contracts will remain in place for 2023/24 for the majority of the Trust's income allocation, but there has been a shift back towards PbR for elective activity in an effort to help organisations focus efforts to improve productivity and to increase numbers of patients seen and treated. Consequently, although the Trust's planned funding envelope remains broadly the same as 2022/23 overall, there is a much greater risk to income realisation, this estimated at circa £60-£70m if the activity targets are not achieved in full. Other key risks to delivery of the plan for 2023/24 are continued industrial action by various staff groups, which has the impact of disrupting the ability to deliver elective recovery and also causes increased costs over the strike days; these strikes and their resolution is outside of the Trust's control. Other workforce concerns include the potential for continued high sickness levels which the Trust has set an internal improvement target for in addition to a target to reduce turnover, thereby reducing the impact of the difficulties in recruiting all levels of range of staff groups that persist across the wider NHS. It also must be noted that the breakeven plan relies on achieving an historic high WRP target of £136.4m, which currently poses an estimated financial risk of circa £40m to the Trust. Therefore, at the end of month 2, year to date to 31st May 2023, the Trust has delivered a deficit of £21.7m against a planned deficit of £16.9m, being adverse by £4.8m YTD. This reflects an in-month deficit for May 23 of £8.8m but that also includes approximately £4.6m of income assumed for elective activity commissioned outside of GM as part of a total £12.3m income risk when added to GM Contracts that there is a risk to receipt of, based on indicative activity numbers to month 2. As a result of these results and the indicative forecast to year end, the Trust has enacted the Financial Accountability Framework, through which each area of the Trust meets with the CFO and COO and their respective teams to identify and deliver actions to rectify the financial performance locally. The early indications from this process are improvements in forecasts, but not yet to the level that would bring the financial performance fully back to plan. This is overseen through the AOF and through the Group Recovery Board on a fortnightly basis, which also allows for actions that require cross-site working to be considered and implemented. The Trust is in active procurement for support to the Turnaround team in order to identify and support areas within the Trust to deliver further efficiencies so that the WRP target is delivered recurrently in full. This support is also tasked with identifying any additional non-recurrent opportunities which could support the Trust to deliver in 23/24. A further risk identified through the planning round is the "System Savings" target of £130m which is currently held by the ICB.

1.2	**Run Rate**	In May 2023 expenditure was £230.8m, an increase of £11.4m, over month 1 expenditure. Included in month 2 is two months of the uplift in AfC staff pay, calculated as £6.1m. The remaining differences between months were adjustments between accruals and actuals for the costs of the April junior doctor industrial action in pay of circa £0.9m and in non pay an increase in drugs costs of £4.0m and clinical supplies of £0.7m offset by some small decreases in other categories.
1.3	**Cash & Liquidity**	As at 31st May 2023, the Trust had a cash balance of £170m which has significantly decreased compared to the balance of £194m at 30th April 2023. The cash balance at the end of May was less than the £174m forecast, the main reason for the variance is lower than forecast income as a result of timing differences. The reduction in the cash balance during May primarily reflects the timing of income receipts and capital payments.
1.4	**Capital Expenditure**	The capital plan is currently reflective of the as yet unagreed 2023/24 capital plan submission by GM and is awaiting approval by NHSE. The Trust's element of the submission, with GM agreement, is a total plan of £151.2m, with the GM envelope component being £73.4m. To advance the capital programme whilst the allocation of the GM envelope is finalised, MFT capital leads have been authorised to commence the "in-progress and contractually committed capital" schemes (totalling £33.5m). For the period up to 31st May 2023, total expenditure was £9.1m against a plan of £13.6m, an underspend of £4.5m. Expenditure included within the GM envelope was £5.4m against the original plan of £4.9m, an overspend of £0.5m. The full year forecast for the total capital plan is £118.8m and currently reflects a £32.4m reduction relating to the North Manchester Hospital Programme (NHP) and the delay in the approval for its Phase 2 enabling works bid. In relation to IFRS 16 CDEL, the current 2023/24 capital budget guidance sets out that there will continue to be nationally ring fenced CDEL cover for the impact of IFRS16, though advising it is subject to future updates and further application guidance. The current plan submission totals £45m, however, the level of CDEL cover available is still subject to approval. For the period up to 31st May 2023, IFRS 16 capital spend totalled £0.3m.

As part of the plan submission for 23/24, sent to the ICB on the 4th May, each of the GM Provider Boards have now been asked to sign up the following wording in relation to the ICB systems saving target.

3.2 Board Statement

3.2.1 "Achievement of this plan is predicated on a number of assumptions and management of risk, and specifically requires the delivery of £123m system savings, which is in addition to the challenging efficiency targets already built into all organisational plans. For planning purposes, the £123m system target currently sits within the NHS GM plan, but all NHS organisations recognise that there is a collective responsibility of all organisations in the system to manage and mitigate this risk. To deliver savings at this level, all organisations and all parts of the system will be impacted.

3.2.2 Delivery of this level of savings needs to focus on cost reduction, rather than an expectation of new income, though every opportunity to mitigate will be explored. Current examples include:

- Output from the PWC diagnostic and productivity opportunities identified both for the system and at an organisational level.

- Review of enduring costs resultant from COVID, examples include additional G&A and Critical Care beds as well as specific COVID services such as testing and Medicine Delivery Unit.
- Wider efficiencies and productivity measures, above CIP plans, which could include reviewing more sustainable commissioning of services including decommissioning.

3.2.3 As a result of the findings from the Carnall Farrar review, governance in the GM system is expected to be revised. The current proposal to oversee not just the delivery of the £123m system savings, but also the wider underlying financial pressures and risks, is to develop a system wide PMO that will report into the NHS GM ICB Board via a Board Committee. The PMO will also ensure that GM has sufficient narrative to adequately articulate why the system has seen material increases in its workforce, but a corresponding reduction in activity when compared to pre-COVID levels. The PMO will facilitate the process and agree with system partners the impact on money, workforce, activity and performance metrics, and agree the changes on the impacted organisations.

3.2.4 Delivery of financial and wider performance indicators is not the sole responsibility of finance; leaders across all disciplines must by accountable, recognising that decisions ultimately may impact patients. Consequently, the system must undertake appropriate engagement and complete Quality Impact Assessments (QIA) to ensure there are no unintended consequences resultant from any proposed changes. The Joint Committee of the ICB will balance the QIA and financial benefits in making the decision to approve the implementation of any changes.

3.2.5 The GM system is facing a significant financial challenge, which has been building over several years, and will continue to increase unless recurrent savings are delivered at pace and at scale. It is expected that decisions taken that benefit the overall system could impact differentially on individual organisations. This might include cost reduction schemes that target specific organisations/ sectors as opportunities are identified and prioritised, or decisions about how income is allocated, recognising that whilst there will be engagement with partners, NHS GM has ultimate responsibility and accountability for how resources allocated to the ICB are deployed. **“**

Financial Performance

Income & Expenditure Account for the period ending 31st May 2023

I&E Category	NHSE Plan M2	Year to date Actual - M2	Year to date Variance
INCOME	£'000	£'000	£'000
Income from Patient Care Activities			
NHS England and NHS Improvement	153,703	152,510	(1,193)
ICBs	220,644	224,156	3,512
NHS Trust and Foundation Trusts	742	745	3
Local authorities	6,212	6,211	(1)
Non-NHS: private patients, overseas patients & RTA	1,920	1,677	(243)
Non NHS: other	2,098	2,113	15
Sub -total Income from Patient Care Activities	**385,319**	**387,413**	**2,094**
Research & Development	12,352	12,329	(23)
Education & Training	14,642	14,411	(231)
Misc. Other Operating Income	15,206	14,296	(910)
Other Income	**42,200**	**41,036**	**(1,164)**
TOTAL INCOME	**427,519**	**428,449**	**930**
EXPENDITURE			
Pay	(259,240)	(274,761)	(15,521)
Non pay	(165,585)	(156,586)	8,999
TOTAL EXPENDITURE	**(424,825)**	**(431,347)**	**(6,522)**
EBITDA Margin	**2,694**	**(2,898)**	**(5,592)**
INTEREST, DIVIDENDS & DEPRECIATION			
Depreciation	(11,546)	(10,988)	558
Interest Receivable	1,542	1,801	259
Interest Payable	(8,623)	(8,620)	3
Gain / (Loss) on Investment	0	0	0
Dividend	(1,004)	(1,004)	0
Surplus/(Deficit) before gain / (loss) on investments	**(16,937)**	**(21,709)**	**(4,772)**
Gain / (Loss) on Investment			0
Surplus/(Deficit)	**(16,937)**	**(21,709)**	**(4,772)**
Surplus/(Deficit) as % of turnover	**-4.0%**	**-5.1%**	
Impairment	**(20,560)**	**(8,806)**	**11,754**
Gain / (Loss) on Absorption	**0**	**0**	**0**
Non operating Income	**100**	**0**	**(100)**
Depreciation - donated / granted assets	**(277)**	**(236)**	**41**
Surplus/(Deficit) after non-operating adjustments	**(37,674)**	**(30,751)**	**6,923**

For the year to 31st May 2023, the Trust has delivered a deficit of £21.7m against a planned deficit of £16.9m – an adverse variance of £4.8m.

Income

Year to date income is above plan by £0.9m, however, this includes estimated income associated with the increase in the AfC pay award for 23/24 from 2% to 5% which is not in the original plan. The amount included to the end of May is £5.3m. Excluding this the Trust would be behind plan by £4.4m which is due to:

- Under-performance against CPT drugs of £2.9m
- Under-performance against Other Operating Income of £0.9m (vaccine income, income generation such as from catering etc)
- Private Patient income was £0.4m behind plan
- E&T income adverse to plan by £0.2m although expected to become favourable once the new HEE schedule is released

NHSE have offerred all organisations the opportunity to restate their plans in month 3 to reflect the increase in both income and pay expenditure related to the improved pay award to negate the need to explain the variance each month. Work is ongoing to do this ready for when the actual payroll costs are known, and this re-stated plan will be brought through appropriate Trust governance routes.

It must be noted that providers have been asked to assume full delivery of income related to the Aligned Payment Incentive monies (API), also referred to as ERF, which has been included as required. There is, however, a risk of circa £12.3m year-to-date for undelivered elective activity that could translate in up to £60-70m of risk by the end of the financial year.

Pay

Staffing costs are adverse to plan by £15.5m YTD to month 2 with the estimated impact of the revised AfC pay award accounting for £6.1m of this variance. As noted above, the majority of this variance will disappear in future months upon submission of a revised plan to include it. Excepting this restatement, the adverse pay variance to date is £9.4m – the main reasons are:

- Consultant costs, primarily WLI payments due to cover for Industrial Action by Junior Doctors in April and for elective activity recovery work – adverse £5.5m
- HCA costs were £1.6m greater than plan due to cover for vacancies and sickness
- Under-delivery of WRP targets across the Sites

A detailed review of pay variances is under way to understand the detail at Specialty level with a view to developing mitigation plans to address the adverse variances.

There was a high level of bank staff spend YTD at £4.2m adverse to plan, which was caused by high levels of vacancies, sickness, unplanned enhanced care needs and supernumerary roles (new starters). Expenditure on agency staff was favourable to plan by £1.3m.

Non Pay

The expenditure against non pay categories is favourable to plan by £9.8m YTD although to some degree driven by reduced activity during the Industrial Action days and by the higher number of bank holidays that occured in the first two months of the year. In addition, some, such as the favourable variance against Drugs, are partly related to the lower than planned income received for Cost Pass Through (CPT) items. The key variances YTD are:

- Drugs costs favourable to plan by £5.2m (CPT element £2.9m)
- Purchase of Services from NHS bodies favourable £1.0m due to changes in the SLA with the NCA
- Depreciation on NMGH IT assets is lower than plan by £0.8m
- Balances across other categories accounting for the remainder of the difference

Costs are forecast to increase across these categories as the year progresses with the need to improve productivity and decrease waiting lists to address the need to improve 78ww and 65ww numbers. This will not, however, bring in further income but if delivered will mitigate the risk around activity linked income that is already in the plan.

Waste Reduction Programme

Within the respective Hospital, MCS, LCO and Corporate Control Totals for the year is a Waste Reduction target totalling £60.9m with a further £75.5m to be delivered through schemes developed at Trust level, a total requirement of some £136.4m.

The tables below outline the month 2 23/24 YTD position against the planned savings. The Board is reminded that the phasing of the Waste Reduction Programme is skewed towards the later part of the year, therefore a lower delivery is anticipated in Q1, rising in Q2 and again for Q3 and 4. Against this plan, on a consolidated basis all areas together have achieved slightly above the internal target delivery of £13.0m and above the submitted plan value of £10.4m by £2.7m. Current forecasts show a shortfall in full delivery of the 23/24 programme of £43.6m and work is ongoing to identify schemes to close this gap.

Workstream	Savings to Date				Forecast 23/24 Position			
	Plan (YTD) £'000	Actual (YTD) £'000	Variance (YTD) £'000	Financial BRAG (YTD)	Plan (23/24) £'000	Act/F'Cast (23/24) £'000	Variance (23/24) £'000	Financial BRAG (YTD)
Admin and clerical	502	502	0	100%	2,823	2,823	(0)	100%
Budget Review	169	169	169		327	327	0	100%
Contracting & income	528	528	0	100%	3,133	3,133	0	100%
Hospital Initiative	662	867	205	131%	5,947	6,151	205	103%
Length of stay	186	186	0	100%	1,114	1,114	0	100%
Non Pay Efficiencies	271	270	(0)	100%	1,775	1,774	(0)	100%
Outpatients	2	2	0	100%	11	11	0	100%
Pharmacy and medicines management	140	140	0	100%	837	837	0	100%
Procurement	346	335	(11)	97%	2,601	2,851	250	110%
Theatres	16	16	0	100%	93	93	0	100%
Workforce - medical	740	758	19	103%	4,819	5,764	945	120%
Workforce - nursing	156	4	(153)	2%	939	612	(327)	65%
Workforce - other	206	232	25	112%	1,247	1,273	25	102%
Informatics	375	375	0	100%	2,426	2,426	0	100%
Total (L3 or above)	**4,298**	**4,383**	**85**	**102%**	**28,092**	**29,190**	**1,098**	**104%**
Trust Initiative	8,707	8,707	0	100%	62,442	62,442	0	100%
MFT Total	**13,005**	**13,090**	**85**	**101%**	**90,534**	**91,632**	**1,098**	**101%**

Summary against Target M1-2	YTD
Target	10,407
Actuals (L3 or above)	13,090
Variance to Target	2,683
Lost opportunity (value of schemes below L3)	173
Variance to target if all schemes delivered as plan	2,856

Summary against Target 23/24	Act/F'Cast
Target	136,412
Actuals/Forecast (L3 or above)	91,632
Variance to Target	173
Value of schemes below L3	1,197
Variance to target	- 43,584

Hospital/MCS	23/24 Target	23/24 Actual/Forecast	23/24 Variance	23/24 % Variance
Corporate	5.1	3.0	(2.0)	-40%
CSS	12.6	7.3	(5.3)	-42%
Eye	1.7	1.4	(0.3)	-16%
Dental	0.5	0.4	(0.2)	-33%
LCO	3.8	1.4	(2.4)	-64%
MRI	9.1	6.1	(3.0)	-33%
NMGH	4.6	2.4	(2.2)	-48%
RMCH	6.2	2.2	(4.1)	-65%
St. Mary's	5.8	2.8	(3.1)	-52%
WTWA	11.5	2.2	(9.3)	-81%
Hospital/MCS/LCO Total	**61.0**	**29.2**	**(31.8)**	**-52%**
Trust (Group)	75.5	62.4	(13.0)	-17%
MFT Total	**136.4**	**91.6**	**(44.8)**	**-33%**

Statement of Financial Position

	M12 Restated 22/23 £000	M02 £000	Movement in YTD £000
Non-Current Assets			
Intangible Assets	11,369	11,163	(206)
Property, Plant and Equipment	1,060,566	1,050,148	(10,418)
Investments	858	858	0
Trade and Other Receivables	17,318	17,531	213
Total Non-Current Assets	**1,090,111**	**1,079,700**	**(10,411)**
Current Assets			
Inventories	25,374	25,520	146
NHS Trade and Other Receivables	100,604	106,932	6,329
Non-NHS Trade and Other Receivables	56,004	82,177	26,173
Non-Current Assets Held for Sale	210	210	0
Cash and Cash Equivalents	240,943	169,538	(71,405)
Total Current Assets	**423,135**	**384,378**	**(38,757)**
Current Liabilities			
Trade and Other Payables: Capital	(36,707)	(20,810)	15,898
Trade and Other Payables: Non-capital	(436,632)	(425,326)	11,306
Borrowings	(36,700)	(36,809)	(109)
Provisions	(29,276)	(28,539)	737
Other liabilities: Deferred Income	(51,880)	(67,758)	(15,878)
Total Current Liabilities	**(591,195)**	**(579,242)**	**11,953**
Net Current Assets	**(168,060)**	**(194,864)**	**(26,804)**
Total Assets Less Current Liabilities	**922,050**	**884,835**	**(37,215)**
Non-Current Liabilities			
Trade and Other Payables	-	-	-
Borrowings	(495,308)	(488,846)	6,462
Provisions	(11,423)	(11,423)	-
Other Liabilities: Deferred Income	(2,805)	(2,805)	-
Total Non-Current Liabilities	**(509,535)**	**(503,073)**	**6,462**
Total Assets Employed	**412,515**	**381,762**	**(30,753)**
Taxpayers' Equity			
Public Dividend Capital	471,920	471,920	0
Revaluation Reserve	163,396	163,396	0
Income and Expenditure Reserve	(222,801)	(253,554)	(30,753)
Total Taxpayers' Equity	**412,515**	**381,762**	**(30,753)**
Total Funds Employed	**412,515**	**381,762**	**(30,753)**

There has been a £10.4m decrease in the carrying value of PPE from £1,061m as at 31st March 2023 to £1,050m at 31st May 2023. The decrease is due to depreciation of £11.1m and impairment of £8.8m which has been partially offset by in-year capital additions (including right of use assets) of £9.5m.

Both NHS and non-NHS trade and other receivables increased from £101m and £56m at 31st March 2023 to £107m and £82m at 31st May 2023 respectively. The movement on NHS receivables of £6m relates to the recognition of prepayments relating to insurance of £2m, research and innovation accrued income of £2m and CSS accrued income (largely relating to the Division of Laboratory Medicine and Virology) of £2m. The movement in non-NHS receivables of £26m has arisen from an increase in central accrued income of £19m and an increase in facilities related prepayments of £2m. The increases in central accrued income are driven by additional income relating to the pay award, local authorities and an NHSI performance adjustment.

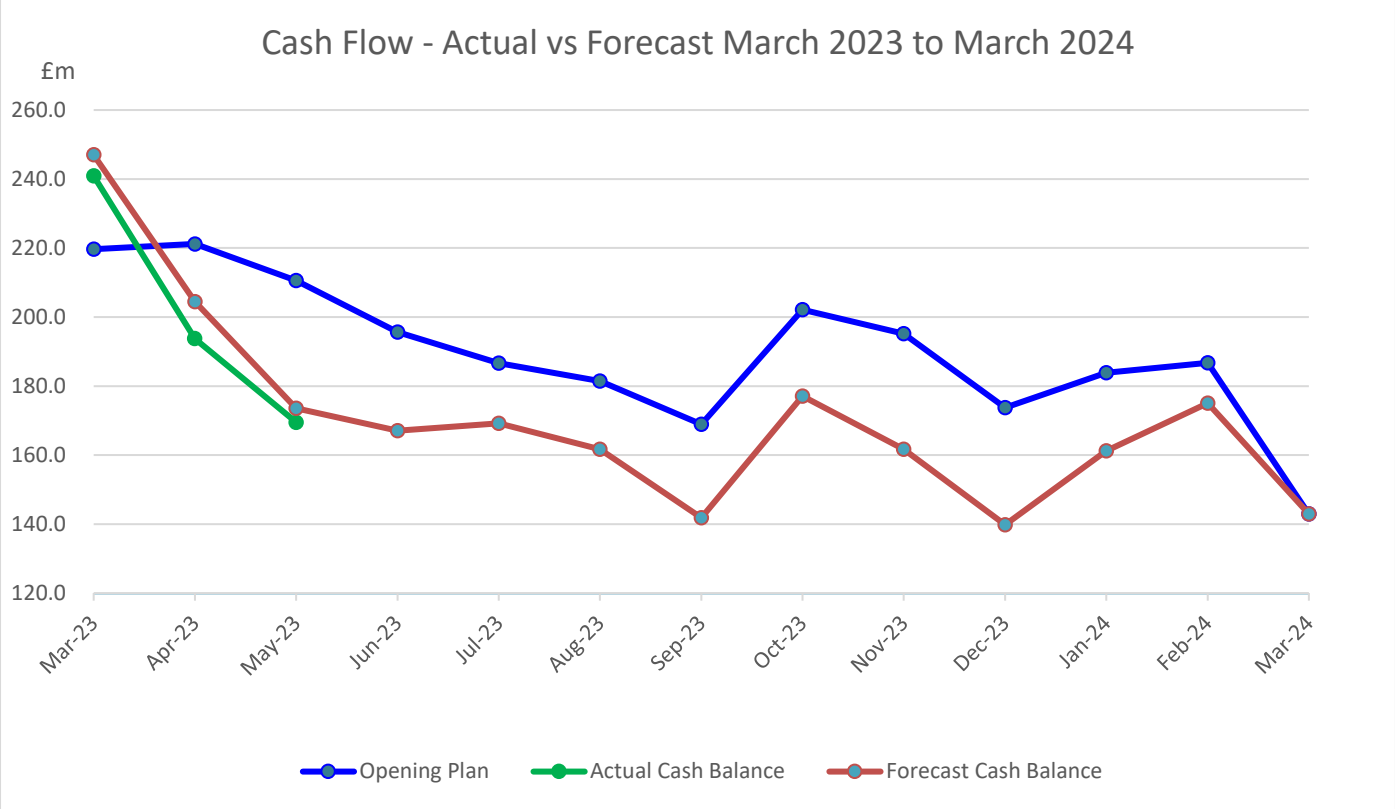
Since the year-end there has been a reduction in non-capital trade and other payables, primarily driven by a reduction of £34m in amounts owed to suppliers. This has been partially offset by an increase in accruals related to system generated GRNI accruals (£6m), the pay award accrual (£6m) and central accruals such as clinical excellence award schemes and for expected inflationary increases in key, high value, supplier contracts including a new contract for gas which is much higher than the fixed tariff that was in place in 2022/23 (£10m).

The escalation of capital activity towards the end of the 2022/23 financial year resulted in a high year end capital creditors balance. This has started to unwind in 2023/24 as a high value of invoices and payments are processed, resulting in a reduction in capital creditors from £37m at 31st March 2023 to £21m at 31st May 2023.

Deferred income has increased from £55m at 31st March 2023 to £71m at 31st May 2023. The main driver of the increase is income received in advance from Health Education England.

The SoFP as at 31st March 2023 is subject to audit sign off at the date of production of this report. The opening balance sheet has been restated for 2 reclassifications in relation to capital payable to receivables (£0.8m) and between capital and non-capital payables (£3.2m).

Cash Flow

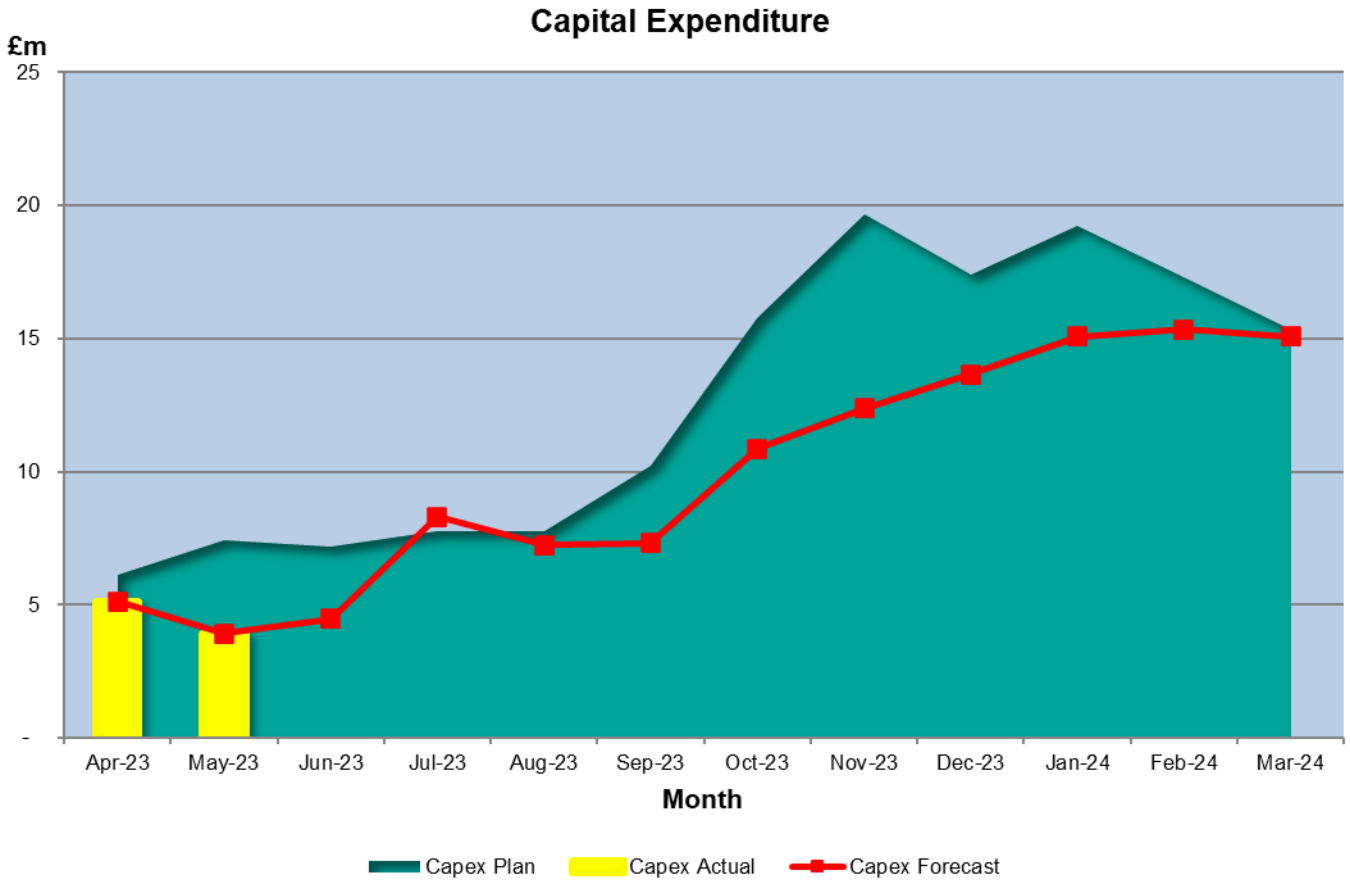


As at 31st May 2023, the Trust had a cash balance of £170m. This has significantly reduced compared to the balance of £194m as at 30th April 2023. This reduction is primarily due to cash outflows relating to staff costs of £129m and payments to suppliers of £92m in May 2023, offset by operating income of £204m.

The cash balance at the end of May 2023 was lower than forecast by £4m, this was primarily due to timing differences between forecast income and income receipts of £19m, we expect to receive this income over the coming months. This variance was offset by capital cash outflows being lower than forecast by £13m and payments to suppliers being £3m lower than forecast, the main driver behind this was no payment being made to Lloyds pharmacy compared to a forecast £2.6m.

The capital spend in May 2023 resulted in a closing capital creditors balance at 31st May 2023 of £20.8m, this is consistent with the balance at 30th April 2023 of £21.5m. This balance is higher than forecast due to the cash capital underspend referenced above. The variances to the plan are mostly due to timing issues and are expected to unwind throughout the remainder of the financial year.

Capital Expenditure



In the period to 31st May 2023, £9.1m of capital expenditure has been incurred against a plan of £13.6m, an underspend of £4.5m. Expenditure included within the GM envelope was £5.4m against the original plan of £4.9m, an overspend of £0.5m.

The underspend is primarily driven by:

- £4.0m New Hospital Programme due to delays in funding approval;
- £1.7m Project RED initial timing delays; and
- £0.8m Estates PDC schemes (i.e Wythenshawe JAG and CDC).

These underspends have been partially offset by overspends, notably:

- £2.3m H&S Backlog, this spend is being managed to be in line with plan by year-end.

The Trust's total capital plan value for 2023/24 is £151.2m. £73.4m of this plan relates to the Trust's allocation against the GM envelope component and is still subject to approval. Whilst the GM envelope is still under discussion, the Trust has authorised capital leads to spend £33.5m in relation to the in-flight and contractually committed capital schemes. The impact of allowing only £33.5m to be spent until the GM envelope is approved will be monitored. Any impact this may have on the continual operation of the Trust will be assessed and action taken as necessary.

The current 2023/24 full year forecast is £118.8m, this is a reduction of £32.4m compared with the £151.2m submitted plan and relates to the North Manchester Hospital Programme and the delay in the approval for its Phase 2 enabling works bid.

The current 2023/24 capital budget guidance sets out that there will continue to be nationally ring fenced CDEL cover for the impact of IFRS16. The current plan submission totals £45m, however, the level of CDEL cover available and the period for which this ringfenced cover will apply are still subject to approval. Consequently, CDEL approval for new leases is being limited to leases already inflight at 31st March 2023 (totalling £7m) until final approval is received. Any impact this has on the continued operational performance of the Trust will also be assessed and action taken as necessary. In the period to 31st May 2023 IFRS 16 capital spend totalled £0.3m.

Agenda Item 9.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Deputy Chief Executive/Hive SRO
Paper prepared by:	Dave Pearson, Programme Director
Date of paper:	July 2023
Subject:	Update on the HIVE programme
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The implementation of Hive supports the delivery of MFT's Vision and all of its Strategic Aims.
Recommendations:	The Board of Directors is asked to note the progress made since Go Live completion and the significant progress made in the first phase of Stabilisation.
Contact:	Name: Julia Bridgewater, Deputy Group Chief Executive / Hive SRO Tel: 0161 701 5641

Update on the HIVE Programme

1. Background and recap

1.1 As one of the largest NHS Foundation Trusts in the UK, MFT now has an Electronic Patient Record (EPR) solution, **Hive**, which will support its vision to be a world-class academic and teaching organisation.

1.2 Julia Bridgewater, Group Deputy Chief Executive, remains the SRO for the programme and continues to provide **dedicated Executive level oversight** and leadership, ensuring optimisation and benefits realisation are achieved.

1.3 It is nine months since Hive 'Go Live' (8th September 2022). The programme currently remains in the stabilisation phase but is transitioning to the optimisation phase where Hive becomes the key enabler for MFTs ambitious digitally enabled **Transformation Programme**. MFT now has all the components in place to deliver this single Trust wide ***Clinically led, Operationally delivered and digitally enabled*** **strategy.**

1.4 This paper provides an update on key progress in the Stabilisation phase since the last Board and outlines the priorities for 2023/24 including the changes in governance as Hive pivots from a programme of work to the key enabler for our Transformation Strategy

2. Hive Stabilisation Phase Update

2.1 Considerable progress has been made during the Stabilisation Phase. The Stabilisation Governance, overseen by the Hive Senior Responsible Officer (Julia Bridgewater), has further matured with the formation of the Hive Delivery Authorities.

2.2 The three Hive Delivery Authorities are: Inpatients, Outpatients and Support Services. Following the appointment of a **Clinical Chair** for each authority and a paediatric clinical co-chair, the authorities were formally launched in May 2023. Membership of the authorities is made up of Hive, Technical, Transformation, Business Intelligence, Epic, Clinical and Operational Hospital/MCS representatives.

2.3 Reporting into the Stabilisation Board, the Hive Delivery Authorities are responsible for:

- Overseeing the **prioritisation**, design and delivery of Hive Stabilisation, Optimisation and Benefits Realisation workstreams, which require Hive build; transformation; training and technical solutions.

- Ensuring that all Trust workstreams that require Hive enablement are included in a **single set of delivery plans** which are prioritised against the Trust's annual plan/priorities.

2.4 The Hive Delivery Authorities are **key enablers** supporting the Trusts Productivity and Improvement Programme for 2023/24 and will ensure capacity for delivering Hive solutions is aligned accordingly.

2.5 Throughout life of the Hive Programme, Deloitte have been providing external assurance to the Board via formal gateway reviews. The fifth and final Gateway review report was submitted to the EPR Scrutiny Committee on 26th April 23. The scope of the final Gateway review was to: consider initial progress since Go Live, governance for optimisation delivery and progress on benefits retaliation (see section 8).

2.6 Deloitte, highlight the design and implementation of a **single, digital transformation strategy**. The launch of the Delivery Authorities aligns to this recommendation and will help provide a **single route for prioritisation and delivery of the MFT 23/24 Plan** and a firm platform for future delivery.

2.7 The overall operating framework for 2023/24 is the most challenging for the last decade however, with **Hive as the vehicle for change and transformation and recovery**, MFT looks uniquely placed to navigate this challenge and those that follow in the years to come. The **Carnal Farrar Elective Recovery** work encompasses the Hive pathways and reporting required to support the elective recovery plans.

2.8 A key escalation theme since December 23 has related to the **Administration Workstream**, where a number of escalations in relation to Hive build and training of staff have been addressed. To ensure effective management and oversight, a muti-disciplinary team (MDT) was established with representation including Hive Applications, Business Intelligence, Group Performance, Clinical leadership and Data Quality. A root and branch review has taken place which has informed a continuous development plan, to which significant resource has been dedicated. The issues continue to be overseen by the MDT and reports directly into the Data Quality Board.

2.9 MFT went live using the May 2022 version of Epic's software. Epic release quarterly upgrades of their software and MFT has committed to taking a minimum of two upgrades each year. This is important to ensure that we have the latest and most enhanced functionality for our staff.

2.10 On the 22nd of June 2023 **MFT undertook the first upgrade since Go Live**.

2.11 The benefits to the end user and the organisation of the upgrade include**:**

- Delivery of up to date software and functionality within the Hive system- the most up to date features will be available to MFT.
- Some clinical pathway developments identified via Pathway Council Oversight Committee, (PCOC) , require the additional functionality that the upgrade provides to be able to progress these developments.

2.12 Significant planning and testing of the upgrade took place to ensure it was compliant to MFT bespoke workflows and to assess the timing and operational and clinical management of the duration of downtime. Dedicated Training and communication materials were developed to support the front line teams alongside the implementation of

a command and control structure to manage any issues. The upgrade was **successfully implemented with safe and effective management of the downtime.**

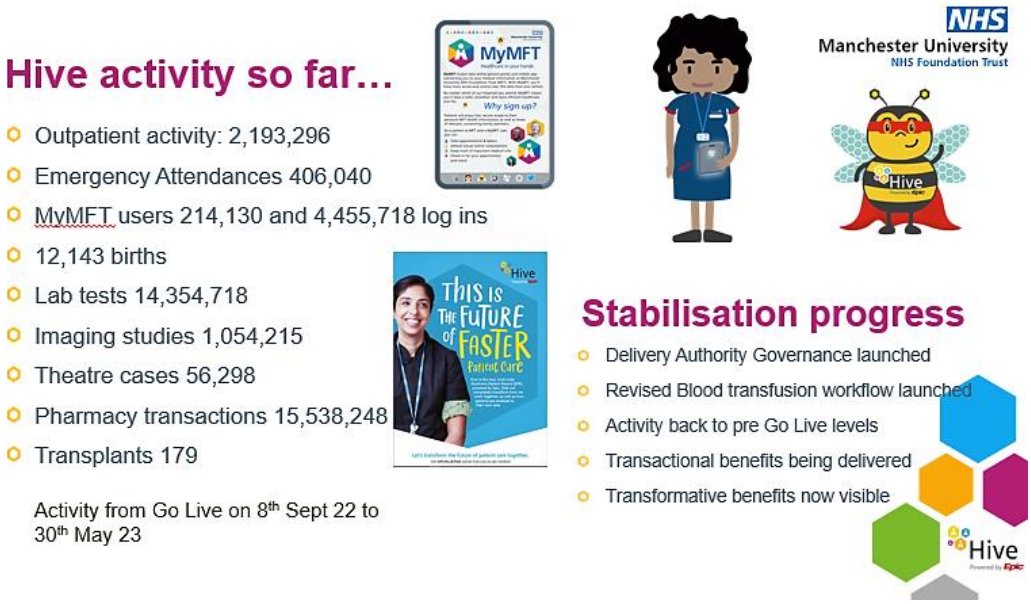
2.13 Planning and business case development is underway for the delivery of **Epic Hyperdrive** project.

2.14 Hyperdrive is Epic's new lightweight and web-enabled client application replacing the Classic Hyperspace. MFT must complete the move to Hyperdrive in line with the Epic EPR upgrade programme as future releases of Epic upgrades will become non-compliant with the legacy Hyperspace. High level benefits of Hyperdrive for end-users and the organisation include:

- A more readily available functionality enhancements & future upgrade process
- A potential to provide future reduction in required licences
- A more streamlined access to the Hive EPR
- Improved opportunities for device integration

2.15 Project Board governance is established for Hyperdrive which reports into the Stabilisation Board with progress updates. The current plan is to commence and complete Hyperdrive rollout in Q4 for 23/24 (Jan to March). No system downtime will be associated with the Hyperdrive rollout

2.16 A summary of the Hive activity so far and stabilisation headlines is as follows:



3. Training – Stabilisation progress Update

3.1 Training teams across Hive and other IT systems continue working with all stakeholder groups to develop **Future State Training**. The team have been trained in the production of eLearning and the lesson plans across the professions have now been signed off with stakeholders. The team are now working on bringing the training materials into an eLearning format so that they are of a higher standard and easier to access.

3.2 Over the next three months the remaining materials will be signed off and launched within the Learning Management system across each profession. The Training Team will work closely with the Workforce systems team to deliver this and it will be aligned to the new starters during August - October when MFT sees the largest intakes across all the professional groups.

3.3 The Training team have been pivotal to key organisational delivery priorities, in particular supporting:

- Preparation and real time support for the **Junior Doctors Strike** periods
- **Outpatient Productivity** – supporting the clinician personalisation campaign to maximise the functionality in Hive
- Onboarding and training plans for **NCA colleagues** as part of the **disaggregation** work
- Members of the **Delivery Authorities** to ensure training needs are considered and explored

4. Governance and Risk Management

4.1 Robust external assurance arrangements have remained in place with Deloitte providing regular gateway reviews. The final Gateway review (Gateway 5) was undertaken in March 2023. The report was presented to the EPR Scrutiny Committee on 26th April.

4.2 The Deloitte Gateway 5 review highlighted a number of key achievements:

- Leap forward in Trust Wide digital maturity
- Unified data sets and standardised workflows across x10 Hospitals
- Staff empowered by capabilities of Hive
- Ownership of teams in benefits delivery, supported by effective leadership & governance structure
- Progress on cloud-based approach for analytics
- Radiology single hospital waiting lists
- Outpatient improvement programme

4.3 As outlined at the start of this report, the overall key recommendation from the Deloitte Gateway 5 review was for MFT to agree a **single, digital transformation strategy** i.e. ensuring that there is a single governance process in place to manage MFTs new digitally enabled operating model.
This has now been initiated by the launch of the Hive Delivery Authorities and the Trust's productivity and Improvement Programme.
The supporting recommendations use Deloitte's 'Insight Driven Organisation' framework and focus on: People, Process, Data and Technology. The recommendations relating to benefits realisation have been incorporated into the Hive benefits workstream (see section 8)

4.4 Given the size and complexity of the programme, the standalone EPR Scrutiny Committee which has met on a bi-monthly basis chaired by Gaurav Batra, Non-Executive Director will continue to oversee the programme with the Committee now moving to quarterly meetings.

4.5 The management of the Hive Programme has had a robust risk management and strategy in place that continues to align to and report directly into the Trust Group Risk Oversight Committee (GROC) as required. This has enabled clear executive ownership on Hive risks and also ensured that the risks were assessed and mitigated in line with interdependences on all the other Trust workstreams.

4.6 The high priority optimisation project outlined in the schematic below relates to **Blood Transfusion**. Implementation of the third-party system was moved to optimisation before Go Live as it was not safe to proceed and the legacy laboratory system was retained. The workarounds that are required as a result are proving difficult for both laboratory and clinical staff. Given the substantive solution will take approximately 12 months to deliver, a review of the current workarounds has taken place with a number of recommended actions required for implementation. These actions have now been taken forward with revised Hive build improving and simplifying the process and this has been supported by a Trust wide training and engagement plan. Given this risk affects all stakeholders and needs to be managed and overseen across teams, the risk has been escalated to a level 15 (high level) on the Trust Risk Register and has been reported into GROC ensuring Board level oversight.

4.7 As outlined in section 2, management of the escalations in Administration Workstream remains a high priority. There is a robust executive led process in place ensuring that these escalations are managed effectively and that patient safety is prioritised.

5 Communications and Engagement

5.1 The Communications team has continued throughout May to support a number of key Hive workstreams to ensure staff and stakeholders are supported and informed.

5.2 Throughout May and continuing into June the team supported the high priority optimisation **Blood Transfusion** project. As the Blood Transfusion Workflow Group worked to improve the current workflow, with the aim of creating a smoother and more efficient process for staff, the team supported to develop a dedicated hub on the Trust intranet. This hub acts as a one stop shop for staff to access policies and tip sheets, video demonstrations and latest updates. A virtual engagement session was held on 1st June and an ongoing communications plan is in place to keep staff informed as work continues.

5.3 In May, more **MyMFT** (MFTs patient portal) promotion and patient support was rolled out across our hospital sites and across our website and social media. Simple sign-up guides were printed for easy reference and distribution in clinics and departments. Alongside the roll out of targeted leaflets and pullup banners highlighting the unique benefits of MyMFT for parents, carers and maternity patients.

5.4 **International Day of the Midwife and International Nurses Day** took place in May allowing us to reflect on the unique opportunity the Hive programme has brought NMAHP colleagues. To recognise the vital contribution that both groups make to MFT and its digital future, the Hive team released a new case study (available on the MFT website) which outlines the key role played by digital NMAHP professionals in Hive's implementation and the benefits these new roles have brought. Interviews with Digital Nurses and Midwives were also shared on the Hive Twitter account.

5.5 In June the communication team worked alongside the Emergency Preparedness, Resilience & Response Team (EPRR), Operational and Clinical teams to provide guidance for staff and external stakeholders where necessary for the **upgrade to the November 22** version of the Epic system. The team created comprehensive support in the form of education sessions, easy step guides and reminders of policy and processes

5.6 The communications team have also supported the preparation and communication materials for the planned **Epic post go live visits** that are scheduled in July working with the Hive Programme team and the Epic teams

5.7 As highlighted above work is continuing to capture emergent **Hive benefits** and the development of a number of early insight and benefit case studies is underway. This work is in partnership with the Benefits Realisation and Transformation teams and is looking to showcase early benefits that have been seen by different services, professions, and patients.

6 Technical Update

6.1 The Technical teams have continued to support the system and responsibilities now sit within the Informatics business as usual structure within the IT Operations and IT Infrastructure teams. To ensure comprehensive oversight continues, a dedicated Technical lead is continuing to aid collaboration and cross team working with Hive and the future state governance of Delivery Authorities. The lead will also support the Director of Technology with broader escalations and service improvements across the Technical team.

6.2 Through collaboration across the Application (Hive and Connected), IT Operations and IT Infrastructure teams there continues to be refinement of and improvement on processes, ensuring that the good elements learned from Go Live are embedded and built upon. This has enabled and will continue to support a dynamic and fast response to any escalations from clinical and operational leads.

6.3 Access & Identity – The improved workflow for junior doctor intake has been successfully used for the May intake following collaboration between User Provisioning, Training team and Medical Education. Further enhancements and improvements will take place over the next couple of months, and we move towards the implementation of the automated solution, IDG.

6.4 Network Issues – A full review has been undertaken on the network issues that have been experienced over the last month. This has resulted in the production of a report from the

external advisors on the short, medium and long term solutions that need to be implemented. A full implementation plan has been developed which will be incorporated into the Informatics portfolio and shared more broadly. The short term solutions have been worked through providing stability to the network.

For NMGH additional activities have been undertaken to replace the desktops within the workstations on wheels (WOWs) with those with better Wi-Fi connection, this work is due to complete on 28th June 2023 and will improve the reliability of the devices connecting to the Wi-Fi network. In addition the planned improvements to the network at NMGH are on plan, with the estates works due to complete 09th July 2023 and the additional access points to commence being commissioned from 14th July 2023.

6.5 Technical issues – Expanding on the programme of clinical and technical walkarounds, the Technical teams will be supporting the Chief Nursing Information Officer, Digital NMAHPs and Delivery Authority Chairs in attending site visits to review the clinical and technical workflows in areas where we have received escalations or concerns on how the workflow is performing. These will enable the multi-disciplinary team to establish the root cause of the issues are and be able to produce action plans to support improvements in the use of Hive and devices. In addition to this, there will be set weekly visits by the IT Operations teams to specific areas across the Trust to seek to proactively support resolving issues. All of these commenced on the 9th of June 2023, information on the planned MDT visits and technical fix visits will be published.

7 Transformation

7.1 Hive is moving from being a 'programme' to being the key enabler in delivering our clinically led, operationally delivered, digital enabled transformation strategy.

7.2 An essential part of this change is to ensure that the Transformation workplan of the organisation continues to be aligned to and respond to organisational priorities.

7.3 MFT has developed new governance arrangements to support the Productivity and Improvement programme focussed on the delivery of the 23/34 organisation priorities. These are focused on delivering high quality care, reducing waits for our long wait patients and ensuring timely care for our most urgent patients.

7.4 As part of the new governance arrangements Improvement Workstreams have been established for: Urgent care & Flow, Outpatients, Theatres and Diagnostics

7.5 The Improvement workstreams are chaired by Hospital/MCS CEOs and will define the priority actions and transformation projects within their pathway. The priorities identified through the Carnall Farrar Elective Recovery work will be focussed through the relevant improvement workstreams

7.6 Transformation and Digital clinical leads (Delivery Authority Chairs) are core members of the Improvement Workstream Leadership teams. Their roles are to support decision making, provide SME (subject matter expert) support to the development of plans

(Transformation and Hive) and ensure appropriate prioritisation of Hive and Transformation resource to support the delivery of the priority plans.

7.7 The current workplans for Transformation are being aligned to the relevant Improvement workstreams and will be prioritised in line with the identified priorities agreed by each workstream.

7.8 Key Transformation workstreams being aligned:

- **Outpatients Improvement:**

Continued focus on Cardiac, Trauma and Orthopaedics and Physiotherapy. The team are at an advanced stage the 'Discovery' phase. Where engagement and discovery has taken place with the services, the team are moving into the 'Design' phase with codesigned solutions being identified and planning on implementation and roll out. As part of the programme wide scale learning and sharing has been developed and disseminated across the Trust through focussed communications packages on Clinician Personalisation, Outcoming and Outpatient schedule guides.
In June 2023 the additional services of ENT and OMFS have been added to the programme with the Discovery phase commenced.

- **MyMFT:**

The outputs of the workshop held in April are being taken forwards with priority projects of work identified as:
- MyMFT pathways refined to ensure electronic letters through MyMFT are not duplicated by paper letters where the patient identified this as their 'preference'
- Developing the work programme to pilot the use of MyMFT for patient self scheduling.

- **Inpatient Discharge Pathway:**

The Hive functionality is being maximised to support the discharge pathways and is a key enabler to the Trust wide Resilient Discharge Programme Back to Basics workstream.

- **Theatres pathways:**

Particular focus of the Theatres Improvement workstream is optimising the Pre Operative pathway and Booking and Scheduling processes

8 Benefits Realisation

8.1 The affordability of Hive is dependent upon the Trust's ability to realise all expected benefits (cash releasing, non-cash releasing and non-financial) from the transformation of its clinical and patient administration services.

8.2 Significant financial delivery risk is emerging within the Hive related elements of the FY23/24 Waste Reduction Programme. At the end of Quarter 1, Plans are £9.5m short of target (c.£10.8M against an expected £19.3M). Focus must be given urgently by the organisation to developing and delivering further value.

8.3 Senior Responsible Officers and Programme leads for current programmes will be asked to submit progress highlight reports primarily aimed at:

8.3.1 improving the level of ownership and accountability for delivery within the organisation; and

8.3.2 providing visibility of blockers to progress and issues requiring escalation for immediate Group support.

8.4 Benefit realisation governance has been aligned to the Trust's new Improvement workstreams and is aligned to the identified priorities agreed by each workstream.

8.5 There is continued focus on reporting of benefits using Hive. It is key that the focus remains on further developing reporting that supports both operational delivery and benefit level reporting.

8.6 Monitoring of non-cash releasing benefits continues, tracked through the new Improvement workstreams and linked through Transformation workplans.

8.7 Emergent benefits and appropriate key performance indicators continue to be progress through the Pathway Council Oversight Committee (PCOC). Work is being undertaken in partnership with the Trust Communications team to showcase some of the initial identified benefits

9 Next Steps

9.1 The Hive Programme is now nearing the end of Phase 2 of Initial Stabilisation Phase, following Go Live on 8th September 2022, and the focus moving in 23/24 will be to ensure that Optimisation and Benefits Realisation are delivered. It is essential however that key stabilisation priorities continue to remain a high priority so that a firm foundation can be built upon.

9.2 As outlined at the start of this report we are now at a critical and exciting juncture in the overall Hive journey as Hive has moved from a programme of work to the **central platform of the delivery** of MFTs organisational priorities, focussed on supporting MFTs **recovery of both the Elective and Urgent Care delivery** as outlined in the operating framework for 23/24 in the immediate term and delivery of sustainable workforce, research and productivity and efficiency transformation.

9.3 Assurance will continue to be provided to the EPR Scrutiny Committee supported by further updates to the Board of Directors.

10 Recommendation

10.1 The Board of Directors is asked to note the progress made since Go Live completion and the significant progress made in the first phase of Stabilisation.

Agenda Item 9.4

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Deputy Chief Executive Officer
Paper prepared by:	Lorraine Cliff, Director of Performance
Date of paper:	July 2023
Subject:	NHS Elective Board Assurance Checklist
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept ✓ • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To achieve high standards of patient safety and clinical quality across the Trust demonstrated through robust processes and timely waiting list management
Recommendations:	The Board of directors are asked to note and accept the contents of the report
Contact:	Name: Lorraine Cliff, Group Director of Performance Tel: 0161 701 5641

NHSE Elective 23/24 Priorities
Board Checklist

1. PURPOSE

A letter received by NHSE on 23rd May 2023 sets out the elective care 23/24 priorities and included a checklist for Trust boards to assure themselves across the key priorities. Boards are being asked to review the checklist to assure plans to deliver our elective and cancer recovery objectives. The three key performance deliverables and metrics to focus on are:-

- Virtually eliminate waits of >65w by March 2024
- Continue to reduce the number of cancer patients waiting over 62d
- Meet the 75% cancer FDS ambition by March 2024

Appendix A provides this assessment.

2. ASSESSMENT

In summary the assessment sets out 7 assurance statements that across MFT has demonstrated areas of good practice and recognises some variances between sites. The below provides a brief summary against each statement:-

Assurance Statement	Summary
Excellence in Basics	Good progress has been made on the validation of patients waiting >12 weeks on our waiting list with 108,000 patients contacted to date. There are circa 30,000 patients that are being locally validated by Hospitals/MCSs where resources and competing priorities across Hospitals is limiting the ability to undertake this routinely and therefore is being managed on a risk stratified approach.
Performance and long waits	Plans are in place to eliminate long waits and deliver zero 65 weeks by March 2024. These plans include improving productivity, insourcing additional capacity, outsourcing to the independent sector and mutual aid.
Outpatients	The scale and volume of our waiting list size and focus on reducing the long waiting patients means that patients are being booked at short notice. The outpatient improvement workstream is working on plans to increase our advice and guidance capacity along with increasing patient initiated follow-ups to deliver:- **1.** 25% reduction in outpatient follow up attendances **2.** Patient initiated follow-ups >5% **3.** Advice and guidance 16%
Cancer pathway re-design	Teledermatology is not in place with GM being behind the curve nationally on this. Roll out is expected from August following clinical criteria sign off.

Activity	Processes are in place to prioritise cancer diagnostics and use of Community Diagnostic Centres, however, there is more work to be done on delivering the 10-day turnaround time from referral to report. Good and innovative services are in place for perioperative medicine with Surgery School and Waiting well initiatives. However, due to the short booking window, ensuring a patient's health is optimised prior to coming in for surgery can cause issues resulting in short notice cancellations. The national optimal utilisation standards for MRI, CT, Ultrasound, Echo and Endoscopy are all being met.
Choice	MFT are using independent sector and mutual aid where they can. However, from experience utilising capacity outside of MFT has proved difficult due to the complexity of our cases and patient choice.
Inclusive Recovery	Work is ongoing to understand the impact of health inequalities on our recovery, this is through our Health Inequalities Board. Within outpatients' analysis has been undertaken to understand the link between HI on our DNAs.

3. RECOMMENDATIONS

1. The recently established Improvement Workstreams for Theatres, Outpatients and Diagnostics need to consider the gaps and prioritise these in their plans.

2. Further evidence needs to be provided to demonstrate the good practice across sites and shared through the improvement workstreams.

3. Hospitals to use the good practice guidance to undertake an assessment at specialty level.

4. The Board of Directors are asked to note the assessment.

NHSE Elective 23/24 Priorities Board Checklist

We ask that boards review the checklist below to assure plans to deliver our elective and cancer recovery objectives over the coming year. There is national support available in each of these areas, please contact england.electiverecoverypmo@nhs.net to discuss any support needs.

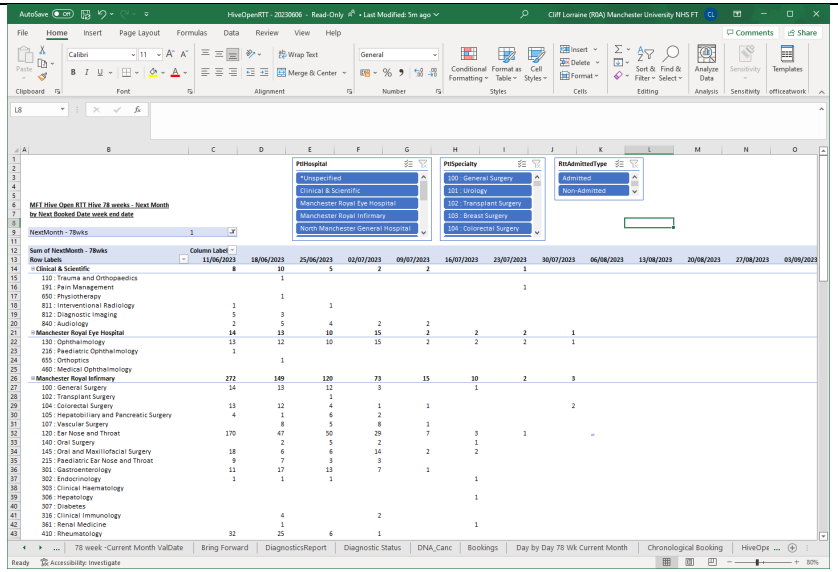
The three key performance deliverables and metrics we need to focus on are:

- Virtually eliminate waits of >65w by March 2024
- Continue to reduce the number of cancer patients waiting over 62d
- Meet the 75% cancer FDS ambition by March 2024

	Assurance Statement	MFT Response
1	**Excellence in basics**	
	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	MFT commenced a programme of validation on long wait patients in October 2022. This was undertaken at Group level for all patients with a Waiting List ID. There are 30,000 patients being validated locally by Hospitals/MCSs. These will include non RTT patients and planned patients. To date 108,000 patients who have waited above 12 weeks have been contacted with an 85% response rate. The 15% none responders are being contacted. Patients who wish to be removed from the waiting list are discharged following clinical review, this is currently 10% of total responders. Our new EPR system records the date of last validation which is monitored through PTLs at Hospital / MCS level. Given the volume of patients to be validated there remains a proportion who have not been subject to a validation within the last 12 weeks. To help manage any risk, validation is being undertaken on a risk stratified basis. For example, within Gynaecology there are 16% of patients (1,129) who do not have a validation comment in the last 12 weeks.
	Are referrals for any Evidence Based Interventions still being made to the waiting list? **Release 3 published on 28 May. It focuses on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology.**	Referrals are still being received which is particularly the case for non-Manchester referrals where GPs refer direct to the Trust. These are identified by the clinicians at clinical triage and rejected or managed according to the Greater Manchester Effective Use of Resources Policy. An audit carried out in 2022 revealed that a small proportion of patients flagged as potential EBIs were inappropriate, the vast majority were appropriate, i.e. 95%.

		The workflow in HIVE alerts the clinician that the patient is being listed for an EBI procedure.
2	**Performance and long waits**	
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	MFT has plans in place to get to zero 78 week waits by end of June. Plans rely on additionality through insourcing arrangements, mutual aid and waiting list initiatives. Improving productivity through theatres and clinic utilisation has also been factored into plans. Capacity and demand modelling has been undertaken as part of annual planning to understand requirements to deliver 103% of pre-pandemic activity levels and zero 65-week waiters by end of March 2024. This modelling has enabled MFT to understand weekly requirements and the actions needed to address actual or potential capacity gaps. Governance structures are in place and monitored through the Accountability Oversight Framework. In addition, a newly established structure has been implemented with 4 improvement work streams focusing on Theatres, Outpatients, Diagnostics and UEC to support delivery. These work streams are chaired by a Hospital/Managed Clinical Service Chief Executive with delivery overseen through the Group MFT Recovery Board chaired by the Group Chief Executive Officer. Where plans rely on additional resources these are prioritised through the recovery board.
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	The ambition and plans are to get to zero by March 2024 the sustainability within some specialties will continue to be a challenge into 2024/25. Work is underway to work through longer term solutions and a focus on 52 weeks at the appropriate time.
3	**Outpatients**	
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place? NHSE GIRFT guidance	An Outpatient Improvement work stream is in place, which includes actions to reduce follow up activity and establish what we can go further/faster with. The size of the non-RTT follow-up waiting list means this needs to be staged to include: • non-RTT waiting list validation. • clinical template cleanse and review as part of HIVE stabilisation. • outpatient demand and capacity modelling to ascertain appropriate splits of capacity to meet all demand (2ww, urgent, routine new referrals and open RTT, plus non-RTT pathways).

		Within St Mary's Hospital / MCS there is a Priority Booking Model being rolled out to align capacity to patient cohorts. Planned non-RTT follow-up validation should reduce FU demand along with plans to increase the use of Patient Initiated Follow Ups. Ophthalmology has a significant number of OPFU as the majority of Ophthalmic practice is undertaken on an outpatient basis. Reducing OPFU in this area is under review to ensure the approach is clinically appropriate. The outpatient improvement programme are focusing on: - • Reducing outpatients follow up attendances by 25% • Increasing patient-initiated follow-ups to >5% • Offering advice and guidance to 16%
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways? Validation toolkit and guidance NHS England » Validation toolkit and guidance published on 1st December 2022	MFTs Group Data Quality Team validate patients on a regular basis and provide a suite of reports for Hospital/MCS operational teams to check and further validate. Booking of patients in a timely manner depends widely on the speciality and urgency of booking, due to the high volumes of long wait patients booking in advance is challenging and will improve as the long wait reduces. The new EPR system (HIVE) provides a forward look across MFT sites/specialities for forward booking and where patients are on the pathway – e.g. awaiting a diagnostic Focus as part of the 78w programme is to ensure timely bookings for new, diagnostic and follow up appointments. There is a central repository that is updated with the daily patient tracking list (PTL) information for Hospitals to use to manage bookings and have oversight of where patients are within their pathway (screen shot below).

		 Across Hospitals/MCS there is regular monitoring of PTLs and local trajectories in place for management of people 65-weeks and over. Weekly performance meetings to monitor progress. Waiting time information is accessible through HIVE for clinicians to review on a regular basis. Saint Mary's Hospital /MCS has produced Local Admin Quick Guides for all key booking & scheduling processes to support consistency and productivity (e.g. reducing DQ issues, patient delays, re-work, confusion re required next steps, etc).
4	**Cancer pathway re-design**	
	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care? Using FIT in the Lower GI pathway published on 7*th* October 2022	MFT currently receives c50% of suspected colorectal referrals from GPs who have ordered and awaited result of a FIT test prior to referring. A process is in place to feedback to commissioning colleagues regarding practices who are non-compliant. Within MFT the colorectal teams have agreed the process whereby, if a FIT test would help determine next steps in the pathway, it is sent to the patient and any patients with a negative FIT are stepped down from the pathway and discharged or investigated on a non-cancer pathway. The FIT coordinators are currently funded by the Cancer Alliance until the end of Q2. At that point is that most referrals will then be sent in with a FIT test having been ordered and reviewed by primary care where necessary.

	BSG/ACPGBI FIT guideline and supporting webinar	Regular feedback is being sent to the alliance regarding referrals with/without FIT and whether they are positive or negative results and assessment of ongoing need/training needs in primary care can be undertaken. Below attachments provides the GM agreed progress: - GM Secondary Care FIT Negative Pathwa No FIT attached Pathway Secondary B2005_ii_Using-faecal-immunochemical-
	Where is the trust against full roll-out of tele dermatology? Suspected skin cancer two week wait pathway optimisation guidance	There is a GM process being led by the Dermatology Transformation Group with input from GM Cancer. The Tele dermatology draft model has been developed and shared. There is an action to assess the baseline across GM with regards to infrastructure/system readiness to meet the requirements of that pathway and minimum referral standards which will highlight any gaps and further actions prior to implementation. A community dermatology service specification has been developed but requires refinement and will go through stakeholder engagement throughout June with sign off mid-July. Management of Changes are expected mid-June to Chief Operating Officers, Executive Medical Directors, GM Directors of Strategy, GM Alliance, GM Dermatology providers, Local Medical Council and Directors of Finance. This will be presented to the sustainable services board and the GM Provider Federation Board towards the end of June. Implementation planning will then take place early August.
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways? Best Practice Timed Pathway for Prostate Cancer	MFT is following the pathway with regards to MRI before biopsy but not all MpMRI are carried out by the required timescales. Capacity for biopsy can be an issue with extra lists being provided on a regular basis to cope with demand. Following the cancer deep dive at Wythenshawe Hospital (WTWA), as lead for urology services, they are developing a rapid plan to standardise pathways across all sites and work towards meeting the timed pathway requirements. GM Cancer Alliance is assessing the possibility of and arranging training for nurses to carry out the biopsies going forwards alongside medical colleagues. Changes are currently being made to the Hive System to allow reporting against the

		best-timed pathway measures via the live cancer dashboard and to allow relevant timescales to be viewed easily in PTL meetings. This is planned to be in place by September 23.
5	**Activity**	
	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity? Letter from Dame Cally Palmer and Dr Vin Diwakar dated 26 April 23.	The following standards have been established for any patient referred to the MFT Imaging service as 'D2' (HSC): - Referral to vetting = 2 days - Vetting to booking = 1 days - Booking to Appointment = 3 days - Appointment to Reporting = 4 days Imaging scanning and reporting capacity across all MFT sites is used to deliver these standards. Booking and scheduling teams operate 7 days per week to ensure appropriate booking arrangements are in place for urgent suspected cancer activity. A cancer co-ordinator post for diagnostic services has been established to ensure that escalations within this pathway are made in a timely way.
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	All MFT Imaging capacity is used flexibly to ensure cancer pathways are prioritised. This includes established Community Diagnostic Centre (CDC) capacity within MFT and the additional CDC scanning capacity that is due to open in 23/24.
	How does the Trust compare to the benchmark of a 10- day turnaround from referral to test for all urgent suspected cancer diagnostics?	Imaging HSC average Turnaround times as at (May 2022): • CTC : 14.93 days • CT: 10.62 days • MR: 15.84 days • NOUS: 9.75 days • FI: 21.51 days MR extended TAT in May due to unplanned MR scanner downtime. MR TAT in June (to date) now 12.73 days.
	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery?	Perioperative Medicine is aiming to develop and implement a reservoir of patients (pilot already in place at TEH), which will support management and optimisation of patients prior

	Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations. NHS England » 2023/24 priorities and operational planning guidance NHS England » Revenue finance contracting guidance for 2023/24 Perioperative care pathways guidance	to their TCI date. It is envisaged that this will support patients to Wait Well and to be fully ready and prepared for surgery when they are sent for. Surgery School is a major frontrunner in supporting patients get and be fit prior to major surgery, this is facilitated and provided by the anaesthetic teams. Waiting Well initiative being implemented via Perioperative Medicine at Trafford Hospital, includes frailty assessment, stabilisation of uncontrolled diabetes. Perioperative Medicine are aiming for patients waiting for inpatient procedures being given a date for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. The standard is not widely in place, but it is hoped that post the successful completion of the POM TEH pilot that standards and processes will be rolled out across MFT with the aim that no patient will be listed for surgery until POA has signed off as 'fit'. Patients are contacted at 3 monthly intervals to ensure patients still wish to proceed and in some cases are invited to attend OP clinic. Patients are engaged in decision making conversations via their clinical consultations & then via booking and scheduling as per the MFT access policy NMGH - the roll-out of the perioperative screening questionnaire has been slow to progress as the process required significant resource to phone patients, often with delayed or no uptake from phone calls made. NMGH is trialling a new process to compete the questionnaire at the point the decision is made to list for surgery in OPD. A test of change is scheduled in Breast Service and OPD w/c 12th June with a view to roll-out more widely thereafter.
	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	A dashboard has been developed and is available to hospitals. MFTaverage active utilisation is 72.7% YTD. There is variation across hospitals. Plans are in place to improve to 85% through the Theatre Improvement work stream.


Active Utilisation %
72.2%
Capped Utilisation %
64.9%
Planned Utilisation %
80.4%
Lists
2,825
4 Hour Sessions
4,387.6
Cases
7,724
Avg Cases In Session
1.8
NHS
Manchester Universit
NHS Foundation Trust
Data last refreshed on 06/06/2023
Analyse By
Managed Clinical Service
Organisation
Specialty
Theatre
Measure
Active %
Capped %
Planned %
MCS
All
Organisation
All
Specialty
All
Theatre
All
Session Type
Elective
NHSI Excluded
No
Yes
Session Date
4/1/2023
6/5/2023
Utilisation % Time Series
Active %
Capped %
Planned %
Selected Measure %
Target: 85.0%
80%
60%
40%
20%
0%
41.5%
38.9%
79.8%
78.8%
Apr 2023
May 2023
Jun 2023
Week Start Date
Active % Utilisation by Organisation
Royal Manchester Children's Hospital 80.6%
Manchester Royal Infirmary 77.9%
Wythenshawe Hospital 75.9%
Trafford General Hospital 75.8%
St Mary's Hospital 75.3%
North Manchester General Hospital 72.8%
Withington Community Hospital 53.7%
Manchester Royal Eye Hospital 32.8%
Organisation
Active %
Capped %
Planned %
Lists
Lists Cancelled
4 Hour Sessions
Cases
Avg Cases In Session
Active % Trend
Capped % Trend
Planned % Trend
Royal Manchester Children's Hospital 80.6% 75.4% 92.8% 319 4 419.4 728 1.7
Manchester Royal Infirmary 77.9% 73.0% 83.3% 392 3 856.9 922 1.1
Wythenshawe Hospital 75.9% 69.6% 79.9% 746 4 1,344.4 2,146 1.6
Trafford General Hospital 75.8% 71.2% 88.1% 299 505.8 1,131 2.2
St Mary's Hospital 75.3% 68.3% 83.5% 181 2 362.1 550 1.5
North Manchester General Hospital 72.8% 58.4% 74.8% 418 6 463.9 777 1.7
Withington Community Hospital 53.7% 53.7% 63.4% 13 31.3 63 2.0
Manchester Royal Eye Hospital 32.8% 18.0% 76.6% 457 2 403.9 1,407 3.5
Total 72.2% 64.9% 80.4% 2,825 21 4,387.6 7,724 1.8

<table>
<tr><td></td><td>Is full use being made of protected capacity in Elective Surgical Hubs?</td><td>We continue to identify further opportunities to maximise the capacity at Trafford Hospital. An improvement plan is in place and delivery is being overseen through the Theatres improvement work stream.</td></tr>
<tr><td></td><td>Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?

https://future.nhs.uk/NationalCommunityDiagnostics/groupHome

<table><tr><th>Test</th><th>Utilisation rates</th></tr><tr><td>MRI</td><td>2–3 scans per hour</td></tr><tr><td>CT</td><td>3–4 scans per hour</td></tr><tr><td>Ultrasound</td><td>3 scans per hour</td></tr><tr><td>Endoscopy</td><td>10 points per service list; 8 points per training list</td></tr><tr><td>Echo</td><td>1 scan (including reporting) per 45 minutes</td></tr></table></td><td>Endoscopy

MRI/TGH Standard endoscopy list booked to 12 points AM and 10 points PM - and 12 points AM and PM for WTWA. Training lists booked to 8 points We book to 100 % and any DNA/Cancellations are booked with INPT capacity. Which results in aiming for 90% utilisation.

Reporting - All reports are done on the day of the investigation and the patient is given a copy.
Referral to vetting – implemented a new SOP and rota - vetting is now carried out within 24 hours .
Vetting to booking - for HSC referrals 24 hours (Monday – Friday).

Implementation of THRIVE reporting for endoscopy across MRI/Trafford/WTWA which enables the monitoring of DNA’s, on the day cancellations, list start times/end times, list utilisation, room turnaround times and procedure length time which will help to standardize points per list across the sites. This has enabled teams to carry out audits re DNAs in order to improve the overall % DNA rate.

MR/CT/Ultrasound/Echo

<table><tr><td>MRI</td><td>Average 2.25 scans per hour</td></tr><tr><td>CT</td><td>Average 3.1 scans per hour</td></tr><tr><td>Echo</td><td>1 scan (including report) within 45 minutes</td></tr><tr><td>Ultrasound</td><td>Average 3 per hour</td></tr></table></td></tr>
<tr><td></td><td>Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the</td><td>MFT CDC programme is already live and has a plan to deliver c.100,000 tests in 23/24. Further expansion in capacity is planned from the end of Q3.

Imaging services are operating 7 days currently and a minimum of 11 hours per day. There are plans to increase operating hours for other modalities in-line with the roll-out plans agreed and funded by NHS England.

The capacity is available to MFT patients including those at the Trafford Elective Hub.</td></tr>
</table>

	fastest route for those patients??	The programme has several initiatives to reduce DNA rates, including the deployment of patient navigators who support patients to access our services and engagement of community groups to better understand barriers to access.
6	**Choice**	
	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region? www.dmas.nhs.uk	Mutual aid is being used where possible. MFT has received mutual aid within GM (ENT, OMFS) and region (Alder Hey) and provides mutual aid on certain patients e.g., restorative dentistry, cardiology, gastroenterology. DMAS was utilised for the 78ww position to the end of March 2023. Uptake was patchy and provider to provider level conversations have been prioritised. For 65ww delivery by end of March 2024 we have a plan that clears through internal capacity, GM mutual aid and any local IS capacity.
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	GM IS contracting strategy is evolving, with a shift from IPT and GM-hosted contracts to provider contracts from Q3. Local high-volume IS provision (Spire) has been reduced through COVID and indications are that provider is exiting NHS market. Other providers are being utilised, but these are more limited in terms of patient types they can accept and are not necessarily local to South Manchester. For MRI Independent Sector capacity has been secured for ENT only with Wrightington Wigan & Leigh, this will be via an IPT model until the end of Q2, after which will convert to Sub-Contract and require to be funded. No assumptions were included in the 2023/24 planning as availability of IS was not fully known in the planning stages. However, this has now been embedded as part of RTT 65w recovery modelling to deliver zero by March-2024 T&O have 15 monthly slots under IPT capacity. Insourcing is also in place for Q1 but this is not part of core planning, but additionality used to support elective recovery.
7	**Inclusive recovery**	
	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do	The Trust has always maintained that patients are treated in clinical priority order and do not differentiate between commissioners. As an example:- **RMCH** - specialised commissioned services are allocated capacity in theatre and the

	system plans balance high volume procedures and lower volume, more complex patient care	medical investigations unit using the same criteria as all other services. Capacity is allocated based on clinical need and/or longest waiting time. Specialised commissioned services are treated equally across RMCH. **MRI** - whilst plans have not specifically factored in volume mix of procedures, they do factor in more complex and higher priority patients as part of the theatre capacity modelling to deliver 65w recovery. **SMH -** recovery plans aim to address demand and capacity issues as identified across all services to reduce wait times equally.
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	MFT have a Public Health Consultant leading on health inequalities. This is drawing on local data and work is ongoing to develop a programme of work to address health inequalities. A Health Inequality Board is established chaired by the Group Medical Director. A programme of work has been developed focusing on the Core20plus5 areas. As part of Outpatient programme we are reviewing impact of DNA improvement plans on DNAs per IMD and ethnicity split. St Mary's offer a TIER2 service for gynaecology patients within North Manchester and is aiming to expand this offer to central and south patients to provide equity of access. Where appropriate we are undertaking Quality and Equality Impact Assessments on any service changes resulting from this work.
	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists? CYP elective recovery toolkit	For MRI Paediatric patient cohorts, these have been factored into recovery plans. Plastics surgery supports Paediatric plastic services and these patients have equitable access to additional capacity and elective recovery actions. WTWA also host paediatric theatre on Wythenshawe site where a holistic approach to recover is taken RMCH have undertaken an assessment against the elective recovery toolkit, which identified a number of gaps, the below provides an update on the actions being taken:-

		 cyp-elective-recover y-reporting-templat

Agenda Item 10.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Strategy
Paper prepared by:	Caroline Davidson, Director of Strategy
Date of paper:	July 2023
Subject:	Strategic Development Update
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	All individual strategic developments are risk assessed and monitored through the Board Assurance and Risk Management processes.
Recommendations:	The Board of Directors is asked to note the updates in relation to strategic developments nationally, regionally and within MFT.
Contact:	Name: Tom Rafferty, Director of Strategy Tel: 0161 276 5676

1. Introduction

The purpose of this paper is to update the Board of Directors in relation to strategic issues of relevance to MFT.

2. National Issues

2.1 Government's 2023 mandate to NHS England

On 15 June 2023, the government published the 2023 mandate to NHS England, setting out the key objectives for the service to deliver this year. It has fewer targets and is a shorter document than in previous years to emphasise the government's commitment to deliver on the key concerns of the public and recognise the importance of allowing integrated care systems the freedom to deliver effectively.

The priorities are:
1. Cut NHS waiting lists and recover performance
2. Support the workforce through training, retention and modernising the way staff work
3. Deliver recovery through the use of data and technology.

This mandate is intended to apply from 15 June 2023 and progress will be kept under review until a new mandate is published.

2.2 Government response to the Review of Integrated Care Systems

The government set out its response to the recommendations made by the Health and Social Care Committee in its report - Integrated care systems: autonomy and accountability and its response to the recommendations made in the Hewitt Review of Integrated Care Systems in a single document.

The response says that government remains committed to the development of Integrated Care Systems. Working through NHS England and other national bodies, they will engage with system leaders and stakeholders to share best practice, listen to feedback on how the current arrangement is working and if any changes are needed and continue to align efforts towards achieving better health and social care access and outcomes for their populations.

Attachment A sets out the specific responses to some of the key recommendations.

3. Regional and Local

3.1 Greater Manchester Joint Forward Plan

The Joint Forward Plan describes how Integrated Care Boards and their partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs and be a shared delivery plan for the integrated care strategy. The deadline for publication of the plan is 30th June 2023.

An engagement draft of Greater Manchester's Joint Forward Plan has been shared across the system for review and feedback. The document is based on the six missions in the Integrated Care Strategy; the actions to deliver them; the measures for tracking delivery; and where accountability is held supported by the performance framework and agreed ways of working.

The NHS England guidance states that the plan should be continually reviewed and formally updated on at least an annual basis. In line with this GM ICB intend to further develop the document in particular in relation to the financial sustainability mission and to

keep the momentum on system conversations with a focus on making choices that secure long-term sustainability whilst continuing to improve outcomes for the population of GM.

3.2 Review into the leadership and governance arrangements across GM Integrated Care System

Carnall Farrar were commissioned to undertake an independent review into the leadership and governance arrangements across GM Integrated Care System (ICS). The purpose of the review was to assess the effectiveness of the leadership and governance arrangements currently in place for oversight and delivery and to identify opportunities that will improve how the system can respond to the performance and financial challenges.

A number of recommendations have now been proposed to respond to the findings of the review including clarifying the ICB operating model and developing a strategic delivery plan, a operational plan and a single system delivery unit. The ICB are working with partners from across the system to take the recommendations forward.

4. MFT Developments

4.1 Sickle Cell Disease Pilot

The bid to pilot a new model for the management of sickle cell crisis has been approved by NHS England. The new pathway will provide patients across GM and the North West with more rapid access to specialist advice and care including admission, if necessary, on a 24/7 basis, wherever they live, and bypassing their local emergency department. Implementation of the new services will start This is a real opportunity to improve the quality of care that we offer this group of patients.

4.2 Community Diagnostic Centres (CDC)

Plans for the North spoke CDC in Harpurhey were developed and submitted to NHSE in May and have received ministerial approval. The plans focus on delivering enhanced diagnostic capacity, as well as reducing health inequalities for people living in and around North Manchester. Confirmation of ministerial approval for the CDC North spoke plan has now been received. The CDC programme team has recently expanded to support delivery of the wider programme, including delivery of the North Spoke

4.3 Hospital at Home

Plans to treat more patients at home, avoiding the need for admission and supporting earlier discharge are progressing. A symposium held in June brought together members of the multi-disciplinary team from across MFT, our local GPs, public health and local authority colleagues to consider how we can safely see and treat more patients at home, including developing an enhanced Hospital at Home approach for this coming winter. A second symposium will be held later in the year.

4.4 Vascular Services

The first meeting of the relaunched Greater Manchester and East Cheshire Vascular Network Board took place on 28 June. Membership has been secured from key partner organisations, including all acute trusts. The aim is for the network to operate in an inclusive way to agree, implement and oversee pathways for vascular care across the region and to support the development of the local network hospital sites in line with national guidance. An effective network will be key both in supporting the development of the future model for the move to a single arterial centre and its subsequent success.

4.5 GM Children and Young People (CYP) Recovery Programme

RMCH chairs the Greater Manchester CYP recovery programme. A CYP recovery summit (ICB wide) is to be held on 14th July. The summit includes national speakers from the GIRFT team, national peer models of recovery and excellent practice across outpatients, theatres, prioritisation and engagement. Clinical, operational and transformation representatives from each Trust will take part in focussed improvement planning sessions during the summit. Clinical leads have been recruited for the high volume children's surgery specialities and will be undertaking deep dives with each Trust to identify quick wins on current pathways as well as developing the GM models of care for CYP surgery.

4.6 University Dental Hospital Manchester

Two further workshops have taken place with University of Manchester (UoM) colleagues as part of the process to develop a strategic outline case (SOC) for the redevelopment of the University Dental Hospital Manchester. The process to-date has focused on agreeing the strategic context, case for change and a longlist of options for the project. The next workshop is planned for 21 July at which the longlist of options will be appraised with a view to agreeing the preferred way forward. It is anticipated that a SOC will be drafted in Quarter 3 so that it can be taken through the appropriate governance in MFT and UoM.

4.7 Targeted Lung Health Checks

NHS England has confirmed an accelerated timeline for the roll out of the Targeted Lung Health Check (TLHC) programme. MFT is the lead provider working in collaboration with Greater Manchester Cancer Alliance, The Christie and Northern Care Alliance.

The agreed approach is to set up Community-Based One-Stop Clinics utilising risk stratification and immediate ultra-low dose CT scan of the thorax for those eligible (at-risk, ever-smokers aged 55-74yrs). This is a tried and tested approach, developed by MFT in 2016/7 and now adopted nationally. The roll-out will be based on Primary Care Networks stratified by smoking prevalence, lung cancer incidence and mortality, and deprivation.

5. Actions / Recommendations

The Board of Directors is asked to note the updates in relation to strategic developments nationally, regionally and within MFT.

Attachment A

Review of Integrated Care Systems
Specific responses to key recommendations

Fewer central targets (no more than ten national priorities).	We also recognise the benefit of the centre focusing on a small core set of priorities, which has been reflected in the reduction to 31 national NHS objectives within the 2023 to 2024 priorities and operational planning guidance, and will be reflected in the forthcoming mandate to NHS England
A limited number of ICS targets should carry equal weight to national targets and local outcomes	An effective health and care system is able to respond to both national and local priorities for improving services and outcomes; and progress in delivering those priorities will need to be measured and accounted for. The framework created by the Health and Care Act 2022 provides for the Secretary of State to set national priorities for the NHS through the mandate to NHS England. NHS England uses its planning guidance to translate mandate requirements into operational requirements for the NHS. The recently published plans for primary care, elective backlogs and urgent and emergency care set out key current national priorities for NHS recovery. ICSs bring together NHS bodies, local authorities and their partners to agree how the universal commitments to the public are best met in their areas, alongside any specific priorities for improving services and outcomes for their communities. ICSs should be enabled to set a focused number of locally co-developed priorities
Enable a shift towards upstream investment in prevention Total budget share for prevention should increase by at least 1% over the next five years	The government's immediate priorities for the NHS are clear and have been set out in our recovery plans for elective care, urgent and emergency care and primary care. However, the government agrees that in line with the ambitions of the NHS Long Term Plan, over time the focus for the NHS should increasingly shift towards implementing evidence-based interventions to help improve prevention and support healthier life expectancy. However, we do not agree with imposing a national expectation of an essentially arbitrary shift in spending. To support investment in prevention, NHS England and DHSC will work closely with ICSs, local government partners and NICE to develop practical information and evidence to support local investment decisions. This will include considering the methodologies for developing an appropriate definition for preventative healthcare spending and exploring options for local baselining. Once this process has concluded we will make an assessment on publishing this information.
Payment mechanism flexibility	We recognise the importance of best practice in implementing innovative payment models across the country. As part of the NHS Payment Scheme development process, NHS England undertakes a significant programme of engagement with ICBs and other organisations in England, seeking to understand best practice and effective payment models. NHS England is also

	looking at international comparisons of different payment mechanisms and the resulting impacts they have.
Defining accountabilities - ICBs to be the default mechanism for delivery of national support and intervention).	The principle of this recommendation closely aligns with the approach taken by NHS England in the existing NHS oversight framework
Reconsider the Running Cost Allowance cut	NHS England has set out its policy intent with respect to the delegation of services to ICBs and the transfer of associated budgets. In 2023 to 2024 NHS England completed the delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services to all ICBs. This is accompanied by a transfer of funding, as well as a transfer of staff and functions from NHS England to ICBs. In 2024 to 2025, the intention is to begin formal delegation of specialised commissioning services and NHS England will continue to explore the delegation of further services and functions into the future where it is agreed that ICB-level commissioning is the optimal commissioning model. As part of the 'creating a new NHS England' programme (following the merger of NHS England, Health Education England and NHS Digital), NHS England is also making significant reductions in the size of regional and national teams over 2023 to 2024 and 2024 to 2025. The 10% cut in ICB RCA planned in 2025 to 2026 forms part of the 30% real-terms reduction per ICB by 2025 to 2026, which has been agreed with government and which forms part of NHS financial plans. NHS England's requested reforms within the Health and Care Act 2022 aimed to ensure that resource could be most effectively focused on the front line.

Agenda Item 11.1

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse / Director of Infection Prevention and Control (DIPC)
Paper prepared by:	Michelle Worsley, Assistant Chief Nurse (ACN) Infection Prevention and Control/Tissue Viability
Date of paper:	July 2023
Subject:	Annual Infection Prevention and Control Report 2022/2023
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept ✓ • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To focus relentlessly on improving access, safety, clinical quality and outcomes To improve continuously the experience of patients, carers and their families
Recommendations:	The Board of Directors are asked to: • Note the information provided in the Executive Summary, and • Accept the Infection Prevention and Control Annual Report for 2022/23
Contact:	Name: Michelle Worsley, Assistant Chief Nurse Infection Prevention and Control/Tissue Viability Tel: 0161 276 4042

Infection Prevention and Control (IPC) Annual Report 2022/2023

1. Executive Summary

1.1 The Trust has a statutory responsibility to be compliant with the Health and Social Care Act 2008 (Department of Health, 2014)[1]. Under this Act the Board of Directors are required to receive an Annual Report from the Director of Infection Prevention and Control (IPC).

1.2 The purpose of the Annual Report is to inform the Board of Directors how the Trust's Infection Prevention and Control team (IPCT) has engaged in Health Care Associated Infection (HCAI) Prevention and Control during the period 2022-2023.

2. Purpose

2.1 The Annual Report seeks to provide assurance to the Board of Directors on our progress against the annual programme which is set against the 10 criteria of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections[2]. The Code was updated in December 2022 to reflect changes to the Act itself and the role of IPC including cleanliness in optimizing antimicrobial use and reducing antimicrobial resistance and taking into account of changes to the IPC landscape and nomenclature that have occurred since the COVID-19 pandemic, and the COVID 19 Board Assurance Framework[3] (BAF) released by NHS England during the COVID-19 pandemic.

2.2 The Annual Report details Infection Prevention and Control activity from April 2022 to March 2023, outlining key achievements, and is presented in context of being the first year of recovery following the COVID-19 pandemic.

3. Financial implications

3.1 Whilst it is widely accepted that healthcare acquired infections carries both a human and financial cost, there are no financial implications directly resulting from this Annual Report that is not reported through other programmes of work including, patient flow and patient experience.

4. Risk

4.1. The Group Infection Prevention and Control Committe (GIPCC) provides executive oversight of the Trust's IPC programme, reporting to the Quality and Performance Scrutiny Committee. Risks associated with infection prevention and control matters have been reviewed through the Group Risk Oversight Committee (GROC) during 2022-2023, and monitored at Hospital/MCS/LCO level. There was no material change to the risk assessments in place across the Trust, however as this report identifies, a further focus is required on the controls in place to identify further controls that may be required to mitigate the risks associated with healthcare acquired infections.

5. Communication and Involvement

5.1. The Annual Report has been developed by the Infection Prevention and Control Team.

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[1] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

[2] Health and Social Care Act 2008: code of practice on the development and control of infections and related guidance. Updated December 2022.

[3] NHSE Infection Control and Prevention Board Assurance Framework (V1.11 22 September 2022)

Review, assurance and actions where agreed are undertaken at Group, Hospital/MCS/Levels where required and monitored through the site and group level committees.

6. Summary of Infection Prevention & Control Activity

The following sections provide a summary of activity and performance during 2022-23 that are detailed in full in theTrust Annual Report.

6.1. Governance

6.1.1. The Group Infection Prevention & Control Committee (GIPCC) has responsibility for monitoring infection Prevention and Control activities, as laid out in the key 10 commitments During 2022/23 the GIPCC met four times during the year, chaired by the Chief Nurse/Director of Infection Prevention Control. The GICC Terms of Reference are provided at Appendix 1.

6.1.2. The Chief Nurse & Director for Infection Prevention and Control (DIPC) led End of Year reviews for each Hospital/Managed Clinical Service/Local Care Organisation (Hospital/MCS/LCO and a sepatate review was held for Estates and Facilities). Review meetings were held with the each Director of Nursing, who have delegated responsibility for IPC in the hospitals/MCS/LCOs, supported by their Senior Team, local Infection Control Doctor and IPCNs.

6.1.3. The review meetings provided an opportunity to reflect on the previous year, focus on activity and performance, risks posed and mitigation in place. In addition, where appropriate achievements were celebrated and best practice shared through lessons learnt.

6.1.4. An overview of the End of Year Reviews is provided at Appendix 2.

6.1.5. The Trust Accountability Oversight Framework (AOF) monitors a range of healthcare associated infections that are attributed to the Trust.

6.1.6. Risks associated with Infection Prevention & Control are monitored through Hospital/MCS/LCO IPC meetings, and where escalation occurs, through to the GROC.

6.2. COVID-19 Response and Recovery

6.2.1. 'The COVID-19 response- Living with Covid-19'[4] paper was released early in 2022, updated May 2022, and focused upon the safe removal of national restrictions and moving towards managing the virus as other respiratory viruses are managed. The dominant 'Omicron' variant continued to circulate throughout 2022/23 however the decrease in severity meant that hospitalisation and admission to critical care were less likely, in part due to the success of the national vaccination campaign and the reduced virulence of the virus.

6.2.2. Throughout 2022 - 2023 the Trust continued to respond to fluctuating levels of the COVID-19 virus whilst returning to business as usual.The Trust-wide response of staff in supporting patients, visitors and each other to implement policies and procedures to reduce the risk of transmission of COVID-19 is to be commended

6.2.3. From April 2022 until July 2022 the UK saw COVID-19 prevalence rising with Omicron BA.5 being the predominant strain. There was a slight increase in the severity of the

[4] COVID-19 Response: Living with COVID-19 - GOV.UK (www.gov.uk)

illness which was potentially linked to waning immunity. Due to the national reduction in community COVID-19 testingthere was difficulty in assessing accurate numbers of positive cases although it was estimated that there were nearly 3 million positive people within the UK which is around 5.27% of the population.

6.2.4. The national modelling in July 2022 highlighted the numbers were likely to have peaked at that time and case numbers would begin to fall. MFT continued to respond to the number of COVID-19 positive patients and reflected this in the rapid provision of COVID-19 bed capacity in MFT hospitals as required.

6.2.5. MFT COVID-19 Testing, Streaming and Stepdown guidance was implemented on the 31st August 2022 in response to C1662 - COVID-19 testing in periods of low prevalence[5]. COVID-19 prevalence in the community fell and remained at a comparatively low level as we emerged from the Omicron wave. The likelihood that individuals entering high-risk settings such as the NHS were infectious also reduced and the relative risk of onward transmission into these settings was lower. Therefore, routine asymptomatic testing in a number of settings was paused from 31st August 2022. This included most asymptomatic staff and patient testing in MFT. The pause was reviewed in line with national guidance, community transmission (R rate) and nosocomial cases as we moved into the winter period.

6.2.6. MFT COVID-19 cases peaked again in November 2022 and began to reduce throughout December 2022. The sequencing of COVID-19 specimens processed within the MFT laboratory were mostly lineage BQ.1 which is of Omicron lineage however there was also a growing number of lineage XBB1.5 which was expected to be the next dominant variant within the UK. It was noted the COVID-19 vaccine was still effective against these variants.

6.2.7. Throughout Q4. New COVID-19 varients continued to circulate both in the community and hospital although not with the same frequency as previously reported. No variant of concern was circulating by the end of Q4 2022/2023.

6.2.8. The emergency (EPPR) response to the pandemic was led by the Chief Operating Officer supported by the Chief Nurse/DIPC. The Response and Recovery Group managed the response to the pandemic from September 2021. In 2022 this became the Operational Excellence Group although IPC is no longer a standing agenda item issues can be added to this meeting agenda as required.

6.2.9. The IPC Board Assurance Framework (BAF) was extended to incorporate seasonal respiratory infections, Influenza and Respiratory Syncytial Virus (RSV), as well as SARS-CoV-2 in health and care settings for winter 2022 to 2023. The BAF was reviewed regularly in line with each new version and presented to the Board of Directors and GIPCC. Mitigating actions were implemented to address any gaps in assurance.

6.2.10. The implementation of ‘Living with Covid’ in April 2022 ended many national restrictions within the UK however the UK Health and Security Agency (UKHSA) Infection Prevention Control guidelines remained in place for staff and visitors across all healthcare services.

6.2.11. There remains a continued focus within national guidance towards a risk-based approach in healthcare facilities.Clinical areas undertake a local risk assessment using the Health and Safety Executive (HSE) Hierarchy of Controls to ensure ward and departmental managers are able to safely implement measures to protect staff and patients at times of higher prevalence of respiratory infection i.e. seasonal infections

6.2.12. All SARS-CoV-2 related guidance was withdrawn on 31st March 2022 and a National

[5] www.england.nhs.uk/wp-content/uploads/2022/08/C1662_covid-testing-in-periods-of-low-prevalence.pdf

Infection Prevention Control Manual for England [6](NIPCM) was introduced with a focus on standard infection prevention principles and included more detailed transmission based precautions.

6.2.13. There was continuous surveillance of all COVID-19 positive cases undertaken by the IPC surveillance team. The daily COVID-19 data was circulated at all levels across the Group. Each case was reviewed by the IPC nursing team to ensure that all aspects of IPC standards were being followed and any further actions required put in place.

6.2.14. In September 2022, in line with national recommendations the Trust reviewed COVID-19 guidance on asymptomatic testing of both staff and patients outwith areas where severely immunocompromised patients were cared for. For these groups of patients asymptomatic screening was continued on a risk assessment basis

6.2.15. Following implementation of the guidance staff were no longer required to undertake asymptomatic LFD testing nor record the results on the government portal. . In areas of high risk such as haematology or renal, weekly PCR testing continued on a risk assessment basis.

6.2.16. Throughout 2022 there has been no restrictions to visiting any MFT site except for standard localised restrictions put in place in the event of a ward outbreak of infection, in line with MFT Outbreak Policy.

6.2.17. The trust took part in a Multicentre, prospective study: Effectiveness of rapid SARS-CoV-2 genome sequencing in supporting infection control for hospital-onset COVID-19 infection which was published in September 2022.

6.3. Healthcare Associated Infections

6.3.1. The prevention and control of infection is a high priority for the Trust and there is a strong commitment to prevention of all HCAI Infections. There were 14 incidents of Trust attributable Meticilin Resistant Staphylococcus aureus (MRSA) bacteraemia this year compared to 10 for the previous year.

6.3.2. There was a total of 199 trust attributable cases reported against a trajectory of 174 cases in 2022/23 compared to 196 cases reported in the previous year.

6.3.3. There was a total of 971 Gram-Negative Bloodstream Infections (GNBSI) reported during 2022/23. Of these, 341 cases (35%) were determined to be hospital-onset, a slight increase on the previous year which saw 304 hospital onset cases of GNBSI. GNBSI figures are considered against a locally calculated trajectory informed by the national reduction objective (50% reduction from 2016 baseline). MFT were under the threshold set at 410 cases.

6.3.4. A total of 48 Vancomycin-resistant Enterococci (VRE) bacteraemia were reported during 2022/2023. This compares to 31 reported during the previous year.

6.3.5. There was a total of 572 Carbapenemase-producing Enterobacterales (CPE) acquisitions recorded for 2022/2023, compared to 416 for the previous financial year. There were 6 attributable CPE bacteraemia's reported during 2022/2023 compared to 1 bacteraemia reported the previous year.

6.3.6. A CPE task and finish group focusing on delivering improvements and reducing

[6] https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/

acquisition of CPE, commenced in November 2022, led by the Associate Medical Director for Infection Prevention and Control.

6.3.7. The increase noted in attributable healthcare associated infections is concerning. All incidents of CDI and reportable bacteraemia attributable to the Trust were investigated and addressed at the Hospital/MCS Infection Control Accountability Review meetings. Key themes to emerge included:

- Compliance with infection prevention and control policies
- Anti-microbial stewardship
- Delays to commencing isolation and decolonisation therapy

6.3.8. Led by the Assistant Chief Nurse for IPC, each Hospital/MCS/LCO has incorporated key findings into local action plans, which will be closely monitored at both site and Group level through the GIPCC, and through the AOF.

6.4. Antimicrobial Stewardship

6.4.1. The structure of the MFT Antimicrobial Stewardship (AMS) Committee G-AMC was revised, creating a group wide strategic committee with three working sub-groups. The new G-AMC has been in place since November 2021, and is currently chaired by the Medical Director, NMGH. Membership includes senior clinicians and medical directors from all the hospitals in the Group.

6.4.2. In line with the Health and Social Care Act Code of Practice update in December 2022, there have been developments in national and regional antimicrobial resistance (AMR/AMS) structures in NHS England, with a new National AMR lead and a new Northwest AMS lead pharmacist. This has led to further developments in the new Integrated care system (ICS) structure with the formation of a Greater Manchester AMR Board and an AMS committee. MFT has medical and pharmacist representatives on both groups.

6.5. Surgical Site Infection Surveillance (SSI)

6.5.1. The Trust is required to submit a minimum of one quarter of data per year to comply with mandatory reporting for orthopaedic implant surgery. Data was submitted for both hip and knee replacement surgery for routine surgery performed at Trafford Campus.

6.5.2. The national rate of infection for knee and hip replacement for the previous 5 years is 1% and 0.8%, respectively

6.5.3. Across MFT, a total of 321 knee replacement procedures and 272 hip replacement procedures were conducted during the previous four quarters in which surveillance was undertaken, with no patients readmitted due to, or reporting an SSI.

6.6. Cleanliness

6.6.1. The Trust cleaning services were provided by both internal and external contractors/teams. The services at North Manchester, Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units were managed and monitored through internal in-house arrangements with the service managers and local users.

6.6.2. In addition, the standards of cleanliness were monitored and reported for all sites through

the National Standards of Cleaning (NSoC) monitoring, monthly Quality of Care Rounds, the Ward Accreditation Process and the What Matters to Me (WMTM) Tracker. These results informed areas of best practice and areas where additional focus was required.

6.6.3. As required by the (NSoC) Commitment to Cleanliness Charters were publicly displayed in all clinical areas, replacing cleaning schedules, and Star Ratings to demonstrate the standard of cleaning delivered on each Ward/department. Results have been displayed in accordance with the NSoC.

6.7. Outbreak Management – MFT Outbreak Policy Implementation

6.7.1. In total, there were1673 lost bed days for 2022/23 due to outbreaks of diarrohea and vomiting (D&V). A total of 11 wards were closed or partially closed on occasion due to outbreaks of D&V.

6.7.2. There were also outbreaks of Extended Spectrum Beta-Lactamase (ESBL) bacteria (1), CPE (5) and Influenza A (20) between April 2022 March 2023. Control measures were implemented and the outbreaks successfully managed.

6.8. Outbreak Management – Response to Mpox Outbreak 2022

6.8.1. In 2022, there was a worldwide outbreak of mpox (formerly known as monkeypox) disease. MPox is a rare infection most commonly found in west or central Africa, which in May 2022 was classified as a High Consequence Infectious Disease (HCID). The North Manchester General Hospital's (NMGH) Infectious Diseases Unit was assigned as a receiving unit for patients identified as requiring admission, in addition to Sexual Health Services at NMGH and the Oxford Road Campus providing direct advice and guidance to patients who did not require admission but whose health required remoted monitoring.

6.8.2. MFT were a key partner in the North West Regional response, led by the Deputy Chief Nurse, involving multi disciplinary teams from IPC, Infectious Diseases at NMGH, Sexual Health and Employee Health & Well Being (EHWB).

6.8.3. The co-ordinated response also ensured that both staff and public were vaccinated to prevent infection and limit transmission of the virus. The HIVE BUGSY system proved extremely useful in the prompt identification of mpox contacts and facilitated an offer of vaccination to staff and patient contacts.

6.8.4. In the UK, mpox is no longer considered a HCID.

6.9. Water Safety

6.9.1. Water sampling for Legionella and Control of Legionnaires' disease was undertaken in accordance with COSHH Regulation (2002), Approved Code of Practice L8, Health Technical Memoranda (HTM-04) and Health & Safety Guidance (HSG) 274 across Trust sites. Remedial action was successfully undertaken on outlets that did not meet the required standard.

6.9.2. The review of areas classified as Augmented Care for the purpose of sampling for Pseudomonas took place across the ORC and WTWA sites and was agreed by Water Safety Groups. Agreed schedules of sampling for Pseudomonas were produced and

sampling continued in accordance with HTM04-01 Part C.

6.10. Ventilation Systems

6.10.1. The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems. The Group Ventilation Systems Management Safety Policy has been revised to take account of the changes in HTM 03-01: Specialised Ventilation for Healthcare Premises which was published in June 2021.

6.11. Decontamination

6.11.1. The decontamination services within the Decontamination Services Department (DSD) at Oxford Road Campus (ORC) transferred across to the Hospital Sterilization and Disinfection Unit (HSDU) at North Manchester General Hospital (NMGH) and the STERIS facility based in Wythenshawe in July 2021, for the DSD at ORC to undergo a life cycling refurbishment program which is being undertaken through the Trust's PFI Partner Equans. The new Decontamination Services Department reopened in 2023 on the ORC site.

6.12. External Service Level Agreements

6.12.1. The Trust IPC/ Tissue Viability (TV) Team were once again asked to renew the service level agreement (SLA) provision of IPC advice and guidance to St Ann's Hospice across the three North West Hospice sites:

- The Neil Cliffe Centre (based at Wythenshawe Hospital);
- Heald Green; and,
- Little Hulton through a ServiceLevel Agreement (SLA)

6.13. Professional Development

6.13.1. Throughout the year the IPC team continued to support the development of the advanced clinical practitioner role, a new role introduced for the first time in England at MFT. The post-holder will complete their training period in the summer of 2023, and will continue to support the IPC service post qualification. This exciting new role will support the wider team as it continues to develop, and help advance career opportunities in Infection Prevention & Control.

6.13.2. The Infection Prevention and Control Development Pathway, led by MFT Chief Nurse and developed and introduced by the GM specialist workforce for IPC continued to support the development of knowledge, skills, and behaviours in IPC in all healthcare workers throughout 2022 – 2023.

6.13.3. In accordance with the requirements of the IPC Board Assurance Framework (BAF) local Hospitals/MCS fit testing records were transferred to the Central learning hub from October 2021 and uploaded to the national ESR system in 2022/23. A range of key trainers are in place across the organisation to continue supporting the fit testing of staff, external support from Ashfield Healthcare ceased on 31st March 2023.

6.14. Digital Implementation

6.14.1. In September 2022 there was the successful implementation of the EPIC system, HIVE, and specifically the IPC module within HIVE named BUGSY. The IPC team continue to make changes and improvements to the BUGSY system to increase functionality and performance to benefit patient care.

6.14.2. Surveillance dashboards have been developed, as have Hospital/MCS/LCO dashboards which require further refinement with PowerBi to enable information to be analysed in more meaningful ways to support at a glance overview and monitoring of infection prevention and control metrics.

6.15. Vaccination Programme

6.15.1. This year the COVID-19 and seasonal influenza vaccine programmes were combined in accordance with national guidance and were recognised as an essential activity within the MFT Autumn and Winter Plan.

6.15.2. The MFT COVID-19 booster vaccine rollout commenced in September 2022, with co administration of influenza and COVID-19 vaccines. There was mixed response, with some staff opting for both vaccines and others selecting a single vaccine.

6.15.3. As previously reported to the Board of Directors, final uptake figures for staff seasonal influenza and COVID-19 booster vaccine programmes were published in February 2023.

- Seasonal Influenza vaccine: 50.6% (National 51.8%, Regional 50.3%)
- COVID-19 booster vaccine: 49.4%[7] (National 50.1%, Regional 45.9%)

6.15.4. Through MFT Flu Engagement Groups stakeholder feedback has been collected to investigate the reasons for low flu vaccine uptake. These included perceptions of flu as being less of risk due to reduced prevalence, and prioritisation of COVID-19 booster (despite offer for co-administration).

7. Recommendations

7.1. The Board of Directors are asked to:

- Note the information provided in the Executive Summary, and
- Accept the Infection Prevention and Control Annual Report for 2022/23

[7] Of those eligible, i.e., had not recently had COVID-19 infection in preceding days, or had not yet received primary course

The Infection Prevention and Control Annual Report

2022 - 2023

Contents

8. Infection Prevention and Control Arrangements

The Director of Infection Prevention and Control (DIPC)

Professor Cheryl Lenney was appointed as the Chief Nurse and designated DIPC for the Trust from September 2017. Cheryl started working at Central Manchester Foundation Trust (CMFT) in 2002 and was appointed as Chief Nurse/DIPC for Manchester Foundation Trust (MFT) and its predecessor organisation from 2015.

The Infection Prevention and Control Team (IPCT)

Dr Rajesh Rajendran Associate Medical Director for IPC. Rajesh was appointed as Regional IPC Doctor and Medical Microbiologistfrom July 2021 and became Clinical Director of the Division of Laboratory Medicine in November 2021.

Mrs Michelle Worsley is the Assistant Chief Nurse. Michelle started working at the Trust in 1990 and has substantial experience in both adult, neonatal nursing, Michelle was appointed as an IP&C specialist nurse in 2007 and was appointed to the lead Nurse position IPC team in 2020 following her clinical leadership experience before becoming Assistant Chief Nurse in May 2022

Dr Nicholas Machin Consultant Virologist, Clinical Lead for Virology maintained his role as an Infection Control Doctor (ICD). Consultant Virologist, Clinical Lead for Virology and Deputy Head of Service for Manchester Medical Microbiology Partnership. Dr Machin is also an Infection Control Doctor for MFT and currently leads on IPC for RMCH, St Mary's and the Eye and Dental hospital.

Dr Shazaad Ahmad Consultant Virologist continued his role as an Infection Control Doctor. Shazaad helped to set up the Data Science Unit at MFT in the fieldof infection data that has been used to inform regional and national decision making regarding COVID-19.

Dr Ranajoy Sankar Bhattacharya, Infection Control doctor for WTWA, on his first year as consultant at MFT has been sharing his expertise in accountability meetings, outbreak meetings in addition to ad hoc help to the IPC team with relevant issues.

Dr Eamonn Trainor, Consultant Medical Microbiologist, joined MFT in February 2023 and is Infection Control Doctor for North Manchester General Hospital. Dr Trainor has worked as a consultant with an interest in infection prevention and control for almost a decade. Recently he has worked with the Healthcare Infection Society to produce national guidelines for the management of norovirus outbreaks in acute and community health and social care settings

Mrs Lorraine Durham was appointed as Head of Nursing for IPC in February 2023, Lorraine has substantial experience within infection control and has worked across GM within the specialty for over 20 years.

9. Microbiology and Virology Laboratory Services

Microbiology and Virology Laboratory services were provided on-site at the Oxford Road Campus (ORC) by the Manchester Medical Microbiology Partnership (MMMP) Virology

services were provided across the region as well to the Trust.

10. The Infection Prevention and Control (IPC)/Tissue Viability (TV) Team

All IPC services are managed within the Clinical and Scientific Services (CSS). The Medical members of the IPC Team are in the Division of Laboratory Medicine. The Nursing Team are in the Corporate Division of CSS.

Recruitment and succession plans are in place for both the medical and nursing team, to fulfil the need to ensure that the IPC team develops its workforce.

The Trainee Advanced Clinical Practitioner (TACP) for Infection Prevention and Control.

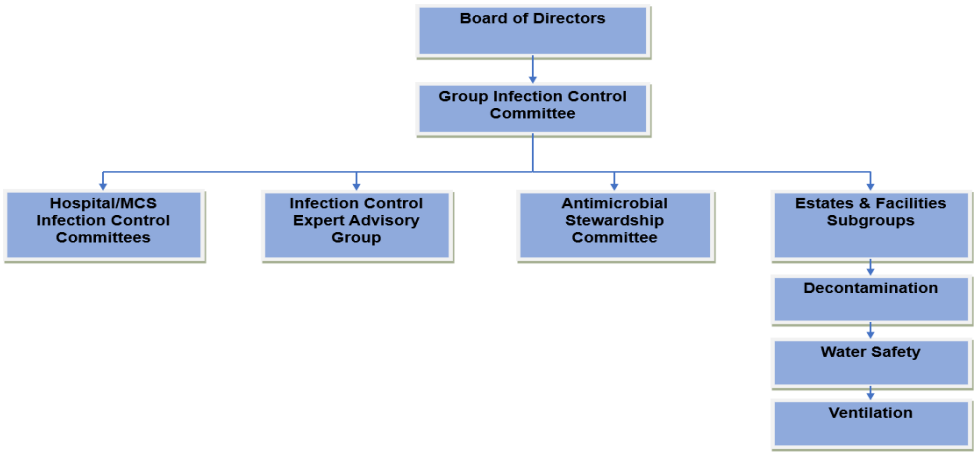
An organogram demonstrating an overview of the structure of the IPC/TV Nursing Team can be found in Appendix 1.

11. The Group Infection Prevention and Control Committee (GIPCC)

The Group Infection Prevention and Control Committee has corporate responsibility for overseeing theimplementation of Infection Prevention and Control activities. The GICC met four times during the year chaired by the Chief Nurse/DIPC. The GIPCC reported to the Group Management Board, and to the Board of Directors via the Quality and Performance Scrutiny Committee. The GIPCC, terms of reference(TOR) can be found in Appendix 2.

11.1. Framework for IPC

The IPC governance framework can be seen below.



11.2. Infection Prevention and Control Structure within the Hospitals/Managed Clinical Services (MCS)/Local Care Organisation (LCO)

Infection Control Committees are in place within each Hospital/MCS and LCO. The day today management for IPC was delegated to the Directors of Nursing by the Chief Nurse/DIPC. Each Hospital/MCS/LCOs appointed a Clinical Lead to support IPC policy and practice across professional groups and represent their Hospitals/MCS/LCO at the GICC.

Each hospital/MCS/LCO presented their Infection Control minutes from the ICC and escalate any issues or concerns. Attendance at the hospital/MCS/LCO meetings includesdesignated IPC nurses and ICDs.

The Chief Nurse/DIPC commissioned an end of year review for each hospital/MCS The review meetings were held individually with the Directors of Nursing (lead directors for

IPCin the hospitals/MCS/LCOs), supported by their Senior Team, local Infection Control Doctor and IPCN(s). The review panel was led by the Chief Nurse/DIPC supported by theAssociate Medical Director for IPC and the Assistant Chief Nurse for IPC/Tissue Viability

The sessions were an opportunity to reflect on the previous year, focus on activity and performance, celebrate achievement, and understand what we had learnt, feedback was very positive from all those involved. A Summary of each review can be found in Appendix 3.

11.3. Service Level Agreement (SLA) with St Ann's Hospice

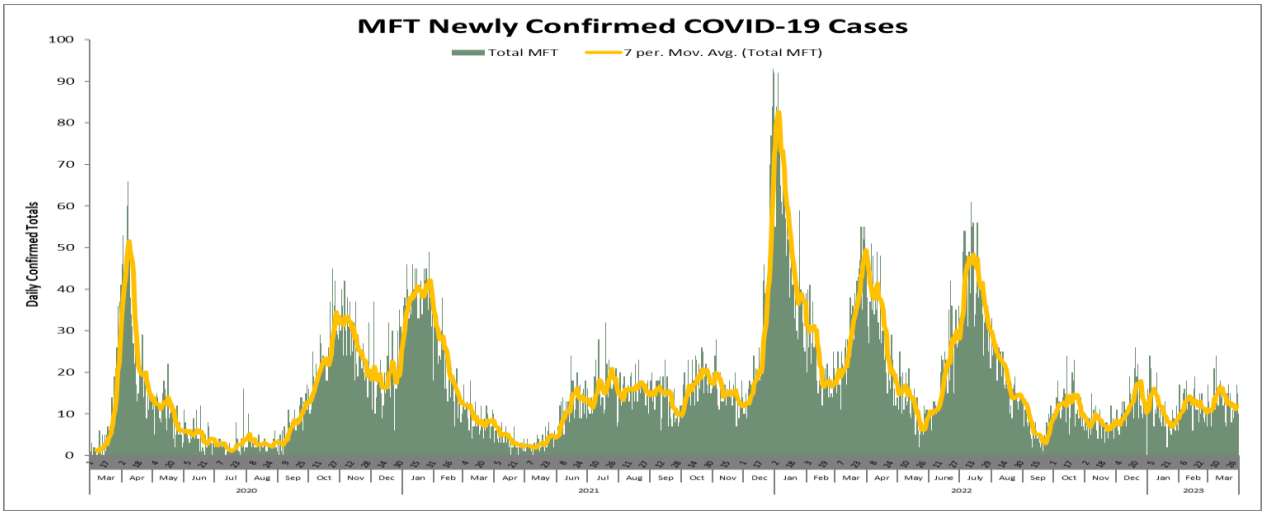
The Trust IPC/TV Team were once again asked to renew the Service Level Agreement (SLA) provision for IPC advice and guidance to St Ann's Hospice across the three North West Hospice sites:

- The Neil Cliffe Centre (based atWythenshawe Hospital);
- Heald Green; and,
- Little Hulton

12. Response to the COVID-19 Pandemic/Recovery from April 2022

12.1. Overview

The prevalence of COVID-19 has continued to decrease throughout 2022. The dominant Omicron variant is not associated with significant morbidity and mortality partly due to the widespread uptake of the vaccine. Graph 1 below shows newly confirmed COVID-19 cases since March 2020 to date (noting NMGH are not included until April 2022).



Graph 1 MFT newly confirmed COVID-19 cases since March 2020

12.2. Trust IPC Framework to Manage COVID-19

The emergency (EPPR) response to the pandemic was led by the Chief Operating Officer supported by the Chief Nurse/DIPC. There were two meetings a week to manage the COVID-19 response and COVID-19 recovery. As we progressed through the pandemic these two meetings were combined as the Response and Recovery Group from September 2021. If there are any issues impacting operational processes then these would be escalated to the Operational Excellence Board going forwards.

The Clinical Sub-Group (CSG) continued to meet and was chaired by the Medical Director. The frequency of the meetings convened varied according to need and is a

forum to discuss and advise on any clinical guidance relating to COVID-19

The Trust responded to changing national guidance The Chief Nurse/DIPC chaired a high-level Expert IPC Group as part of the response to support the rapid interpretation and implementation of IPC guidance. This group reported into the Response and Recovery Group /Operational Excellence Board and the Group Infection Control Committee.

12.3. Board Assurance Framework

NHS England (NHSE), continued to further develop the IPC Board Assurance Framework (BAF) to support all healthcare providers to effectively self-assess their compliance with UK Health Security Agency (UKHSA) Infection prevention and control policies and procedures.

The IPC Board Assurance Framework (BAF) was extended to incorporate seasonal respiratory infections, Influenza and Respiratory Syncytial Virus, as well as SARS-CoV-2 in health and care settings for Winter 2022.

The BAF was reviewed regularly in line with each new version and presented to the Board of Directors. Mitigating actions were implemented to address any gaps in assurance.

12.4. COVID-19 Risk Assessment

The Trust assesses the systems and processes in place against a series of identified risks (Risk MFT/004292).

Oversight of the risks relating to COVID-19 infection is through several channels:

- High Level Infection Prevention and Control Group
- Clinical Sub-Group
- Operational Excellence Group (as required)
- Group Infection Prevention and Control Committee (through the IPC Board Assurance Framework)
- Group Risk Oversight Committee

Throughout 2022-2023, a range of controls were in place to reduce the impact or likelihood of the risk occurring including procedures, detection and prevention:

- A dynamic risk-based approach to patient pathways in place, including use of Hierarchy of Controls and regional/national IPC Guidance
- Supporting range of policies and procedures in place to mitigate risk – most recent reviews as follows:
  - Interim Visiting Policy, updated January 2023
  - Cleaning policy updated in June 2022
  - Testing, Streaming and Stepdown, updates in April and August 2022
  - Pausing of asymptomatic testing in September 2022
  - Review of Fluid Resistant Surgical Mask requirement in October 2022, and March 2023
- A comprehensive vaccine programme continued across the public and healthcare workers.
- A wide ranging system of receiving, assessing, and implementing change with communication channels to advise staff of changes to practice
- The risk was reviewed on a bi-monthly basis.

12.5. Response to Changes in COVID-19 Guidance, April-July 2022

March 2022 saw the reduction in all of National restrictions and the removal of all Covid-19 specific guidance with a move to including all seasonal respiratory infections within the guidance to include Influenza etc. Whilst COVID-19 restrictions ended in many settings, UKHSA Infection Prevention Control guidelines remained in place for staff and visitors across all healthcare services into 2022.

Although the focus remained on seasonal respiratory infections the national guidance moved towards a risk-based approach in healthcare facilities. In line with Government guidance, everyone accessing or visiting healthcare settings across the Trust were still required to continue to wear a fluid resistant facemask(FRSM), unless exempt, to reduce the risk of infection with COVID-19 to themselves and others.
There are no changes to the requirement for staff to don a fit tested FFP3 respirator if they are undertaking/assisting with an Aerosol Generating Procedure (AGP).

Clinical areas were asked to undertake a local risk assessment using the Health and Safety Executive (HSE) Hierarchy of Controls. The risk assessment was documented and reviewed at regular intervals and included:

- Increasing ventilation by opening windows, putting extractors into window, use of air filter machines
- Encouraging patients and visitors to wear a FRSM
- Reviewing the number of people in one room/area to allow for social distancing
- Encouraging staff to have the vaccination and perform twice weekly lateral flow testing to protect themselves and others

12.6. Changes to IPC COVID-19 Guidance, September 2022

In line with the removal of national restrictions there was a requirement to pause asymptomatic testing of both staff and patients. However at that time the Trust was experiencing ongoing COVID-19 outbreaks (23) within MFT hospitals, the R-rate had also increased both regionally and nationally. The burden of COVID-19 patients within MFT beds included 118 COVID-19 positive patients nursed within COVID-19 cohort wards, 32 patients had completed their isolation period and 101 patients were being nursed in side-rooms across the Trust. Therefore the pausing of asymptomatic testing was delayed slightly until the beginning of September 2022.

12.7. Response to the Omicron Surge November 2022

In November 2022 the Trust saw an increase in the number of cases and the sequencing of the specimens processed within the MFT laboratory were mostly lineage BQ.1 which is of Omicron lineage however there was also a growing number of lineage XBB1.5 which was expected to be the next dominant variant within the UK. The reduction in testing nationally made the R rate and inaccurate predictor of ongoing community transmission. Throughout December and the last quarter of 2022/23 COVID-19 continued to circulate, the current variant was less virulent and most in-patients who were found to have COVID-19 were asymptomatic. Those who were symptomatic had significantly reduced severity of illness.

12.8. MFT Hospital Onset COVID-19 Infections (HOCI)

The national definition of a HOCI remains unchanged and is an infection occurring on or after day eight of admission. All incidents of HOCI continue to be investigated and reported to NHSE/I.

12.9. Outbreaks of Hospital Onset COVID-19 Infection (HOCI) Outbreaks

There was continuous surveillance of all COVID-19 positive cases undertaken by the Informatics team. The daily COVID-19 data was circulated at all levels across the Group. Each case was reviewed by the IPC nursing team to ensure that all aspects of IPC standards were being followed and any further actions required put in place.

If a case formed part of an outbreak, (defined as two or more cases of HOCI in a ward within a two week period), an outbreak was declared, and control measures implemented. Daily updates on outbreaks were circulated across the Trust. Each outbreak was reported to NHSE/I and monitored daily for 28 days.

Table 1 below shows the number of COVID-19 outbreaks across ORC, Wythenshawe, Trafford and North Manchester General Hospitals and the Local Care Organisations from 1st April 2022– 31st March 2023. The rise in numbers in July 2022 was due to the surge in the prevalence of the omicron variant.

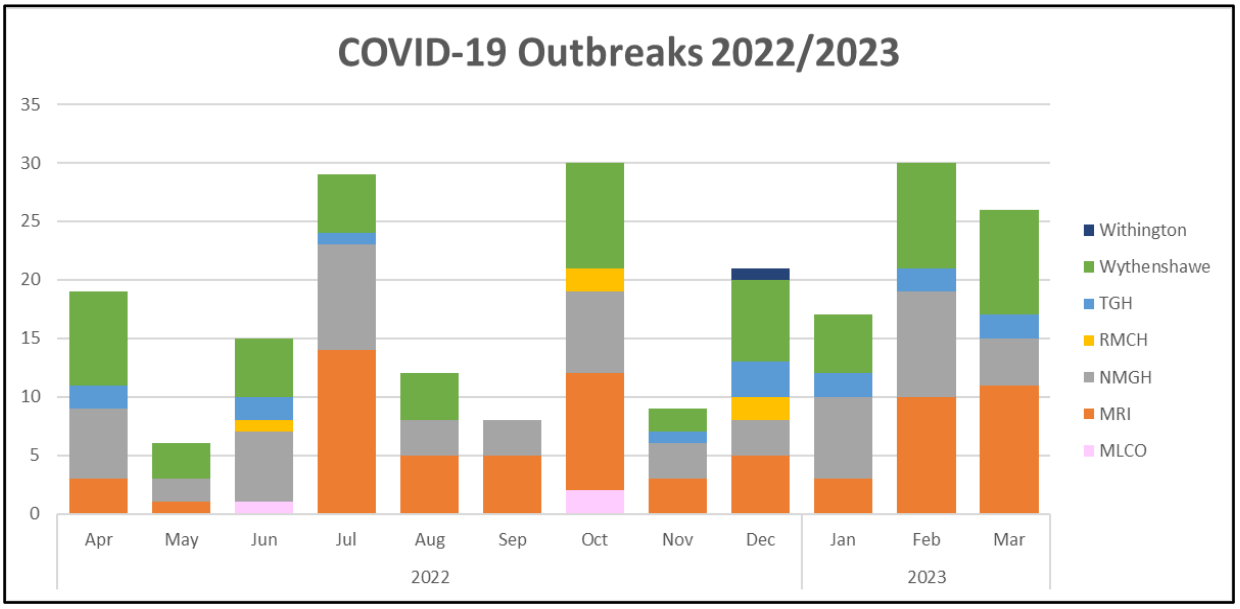


Table 1 COVID-19 outbreaks across MFT April 2022 – March 2023

12.10. Overview of Changes to COVID-19 Patient Screening Testing and Isolation from September 2022.

In line with national recommendations the Trust reviewed COVID-19 guidance on screening, testing and isolation of patients based on a risk assessment, that took into consideration the reduced virulence of the circulating variant. The pausing of testing asymptomatic staff and patients was implemented on 5th September 2022 although some asymptomatic testing remained in vulnerable patient groups or to inform patient placement within augmented clinical areas.

There has been a reduction in the requirement for Polymerase chain reaction (PCR) testing for staff and patients with an emphasis on the use of lateral flow devices (LFD) where testing is still required. The Trust has continued to use PCR testing in most cases, with exceptions being in low-risk elective cases, due in the main to challenges to maintaining accuracy of external reporting.

Patients who are symptomatic and test positive for COVID-19 were moved to a dedicated COVID-19 ward or a single room within their speciality. Patients who test positive and are asymptomatic are risk assessed and may be cared for in a single room. Routine contact screening was also discontinued.

12.11. Overview of Changes to Staff Testing for COVID-19

The pausing of asymptomatic testing in September 2022 meant that the majority of staff were not expected to perform asymptomatic testing with the exception of those working with severely immune compromised patients.

Symptomatic staff were advised to undertake an Lateral Flow Device (LFD) test if they develop COVID-19 symptoms. If positive they were asked to self-isolate for a minimum of five days and return to work after two consecutive daily LFD tests, starting no sooner than day five. Staff who were still LFD positive at day 10 would undertake a local risk assessment with their line manager.

12.12. MFT Visiting Policy

The visiting policy was reviewed regularly throughout 2022 -2023 taking into account national guidance and local intelligence relating to infection prevention and control, in relation not only to COVID-19 but also other infections, for example norovirus. Where appropriate visitors were asked to comply with safety measures, including face masks, PPE, social distancing and handwashing.

12.13. Update on Diagnostic Services to Support the IPC COVID-19 Response

Rapid testing for respiratory viruses, including COVID-19, Influenza and RSV remains in place across MFT to support the diagnosis and management of symptomatic patients, including outbreaks. Rapid testing for ORC and Wythenshawe is provided by laboratory-based testing at both sites. Point of care testing in the Emergency Department at North Manchester General Hospital is due to be launched imminently. A review of services will then be conducted to establish the optimal method of delivery for rapid testing across MFT to guide plans for the 2023/24 winter season.

12.14. Mpox

Mpox (formerly known as monkeypox) is a viral zoonotic disease that until May 2022, was primarily identified in Central and West Africa. There are 2 historical clades of mpox – a Central African clade with a reported mortality of 10% and a West African clade with a reported mortality of 1% from epidemiological cluster and outbreak reports from Africa. Prior to 2022, it was occasionally identified in other countries and related to travel from endemic areas in Central and West Africa

An outbreak of mpox was declared in May 2022 with the majority of cases presenting in London. By the end of May 2022 there had been 196 confirmed cases of mpox within the UK. Whilst the majority of cases were in London a significant proportion of cases were identified in the Greater Manchester area.

North Manchester General Hospital (NMGH) High Consequence Infectious Diseases (HCID) unit was identified as one of two sites, the other being Liverpool University Hospitals NHS FT(LUFT), to act as surge units if required, for admission of severely ill patients.

Sexual Health teams, Infectious Diseases team, Employee Health and Wellbeing (EHWB) and Consultant Virologists in collaboration with IP&C provided expert advice on the implementation of national guidelines and inputted to the GM response to the outbreak.

In June 2022 the Advisory Committee on Dangerous Pathogens (ACDP) advised the mpox outbreak circulating within the UK was no longer classified as a High Consequence Infectious Disease (HCID)

A notable proportion of identified cases were among men who were gay, bisexual and men who have sex with men (MSM) and the majority of presentations were to sexual health clinics, within GM the Hathersage Road sexual health clinic at MFT received a high number of contacts.

MFT pharmacy were asked by the Regional Chief Pharmacist to hold Imvanex vaccine for use in the region, along with LUFT. A vaccination programme for staff who were likely to be exposed or had been exposed to potential mpox cases was established through the Vaccination Service based within MFT Employee Health and Wellbeing (EHWB) services.

MFT EH&W provided vaccination services in mass vaccination events to support the local community ahead of celebrations such as the Manchester Pride festival. Three mass vaccination events were held in preparation for the event. Table 2 shows the uptake of vaccine.

Vaccination	Staff/affiliate staff	Patients	Total
Pre exposure	70	2991	3061
Post exposure	15	23	38

Table 2: Utake of mpox vaccine through MFT clinics

The number of new cases in the UK has now significantly reduced although there has recently been a slight increase again in the London area. The demographics of the patients affected continues to remain the same and MFT continues to perform testing in the Virology laboratory.

13. Health Care Assassiated Infections (HCAI)

13.1. HCAI Performance Thresholds

This section contains a summary of the data submitted through The UK Health Security Agency (UKHSA) mandatory surveillance system. The Healthcare Associated Infections Data Capture System (HCAI-DCS) and summaries of additional alert organisms/trends under local surveillance. Data is presented as number of cases unless otherwise stated.

Surveillance data for North Manchester General Hospital (NMGH) are included from when they joined the MFT (April 2021/2022): prior to that data was reported by the Pennine Acute Hospitals Trust.

During the last 12 months the Trust has seen an increase in the number of incidents of Meticilin Resistant *Staphylococcus aureus* (MRSA) bacteraemia (Chart 1) and *Clostridioides difficile* infection (Chart 2).

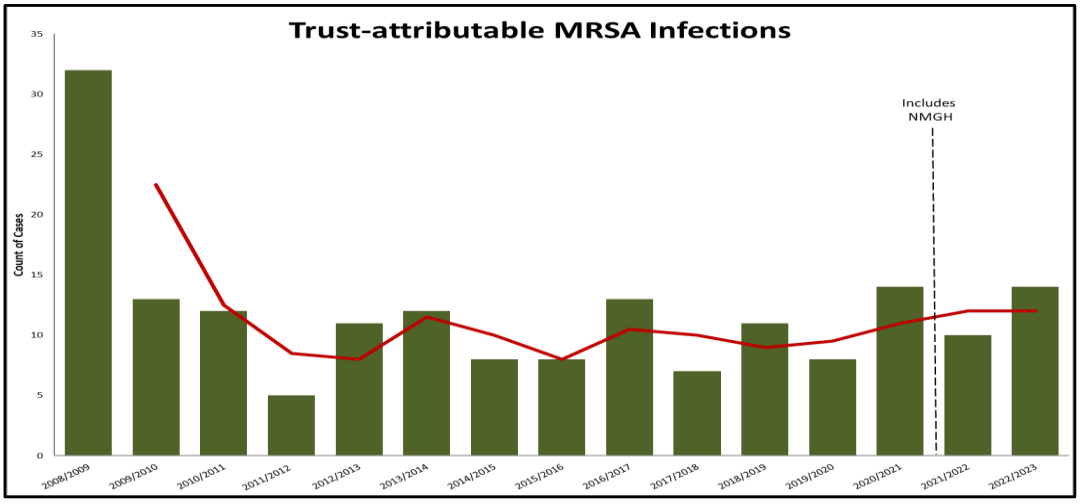


Chart 1: Trust – Attributable MRSA bacteraemia (2008/09 – 2022/23), rolling average indicated by red line

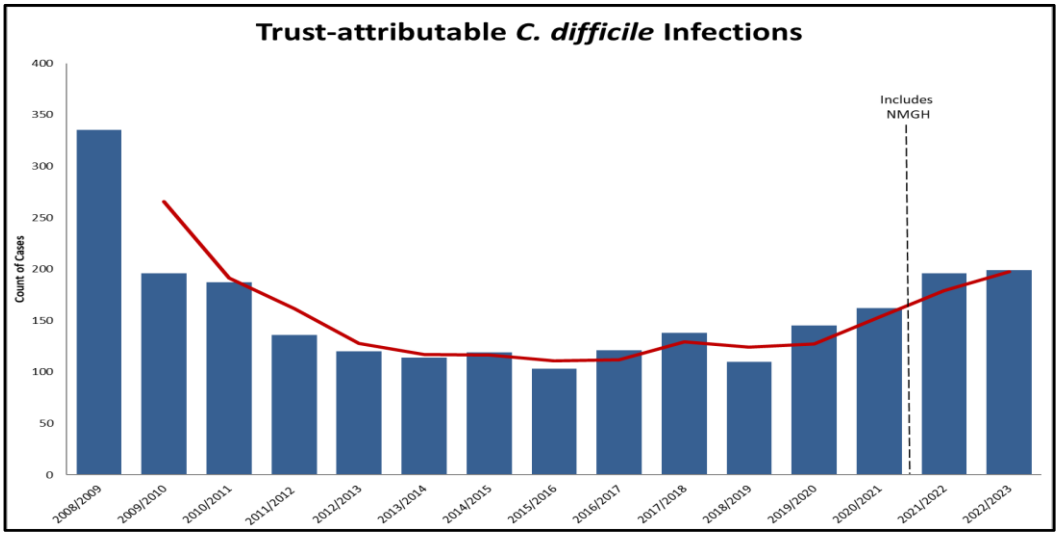


Chart 2: Trust – Attributable C. diff Infection (2008/09 – 2022/23), rolling average indicated by red line

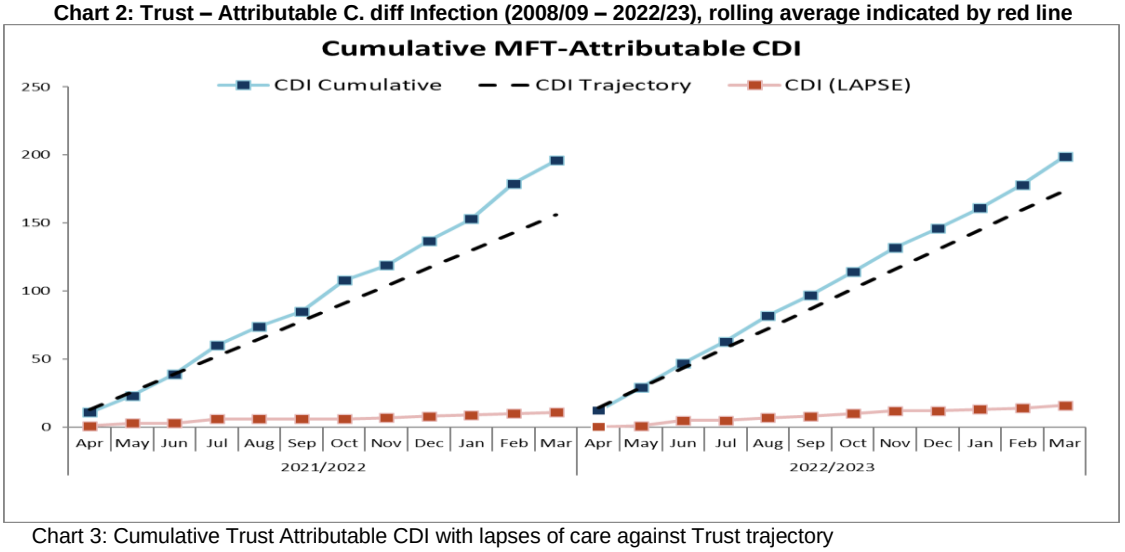


Chart 3: Cumulative Trust Attributable CDI with lapses of care against Trust trajectory

13.2. Key Themes Identified from Investigations into Incidents of MRSA bacteraemia andCDI 2022/23

Figure 1 outlines key themes that were identified from a review of all MRSA bacteremia and CDI cases from 2022-2023.

MRSA Bacteraemia	CDI
• Failure to adhere toMRSA admission screening policy • D elays in commencing MRSA decolonisation therapy. • ANTT process and documentation	• Antimicrobial stewardship • Failure to adhere to policy of isolating a patient with onset ofdiarrhoea • Delays in sample collection for laboratory testing.

Figure 1: Key Themes from incidence reviews

13.3. Gram Negative Bloodstream Infections (GNBSI)

There was a total of 971 Gram-Negative Bloodstream Infections reported during 2022/2023. Of these, 341 cases (35%) were determined to be hospital-onset, a slight increase on the previous year which saw 304 hospital onset cases of GNBSI.

GNBSI figures are considered against a locally calculated trajectory informed by the national reduction objective (50% reduction from 2016 baseline to be achieved by 2023). MFT were under the threshold for GNBSI which was set at 410 cases.

13.4. Meticillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia

Mandatory reporting of all MSSA bacteraemia began in January 2011. A total of 247 MSSA bacteraemia cases were reported during 2022/2023. Of these, 85 cases were determined to be hospital-onset. There is currently no reduction objective associated with MSSA bacteraemia incidence

13.5. Vancomycin-resistant Enterococci (VRE) bacteraemia cases

A total of 48 VRE bacteraemia were reported during 2022/2023 (see Table 3 below for distribution of cases of VRE bacteraemia across MFT). This compares to 31 reported during the previous year and therefore represents an increase. Individual incidents of VRE bacteraemia were investigated and addressed at the Hospital/MCS Infection Control Accountability Review meetings. Cases were seen across the organisation, with most cases occurring in Manchester Royal Infirmary (MRI).

Hospital /MCS	Number of Cases
CSS	11
MRI	28
SMH	0
NMGH	4
RMCH	0
WTWA	5
Grand Total	**48**

Table 3 Distribution of VRE bacteremia

13.6. Carbapenemase-producing Enterobacterales (CPE)

There were a total of 572 CPE acquisitions recorded for 2022/2023, compared to 416 for the previous financial year. There were 6 attributable CPE bacteraemias reported during 2022/2023, but only 1 trust-attributable CPE bacteraemia reported for 2021/2022. Monthlyperformance can be seen in Chart 4 which presents CPE acquistion data for all MFT sites (see section 14.2).

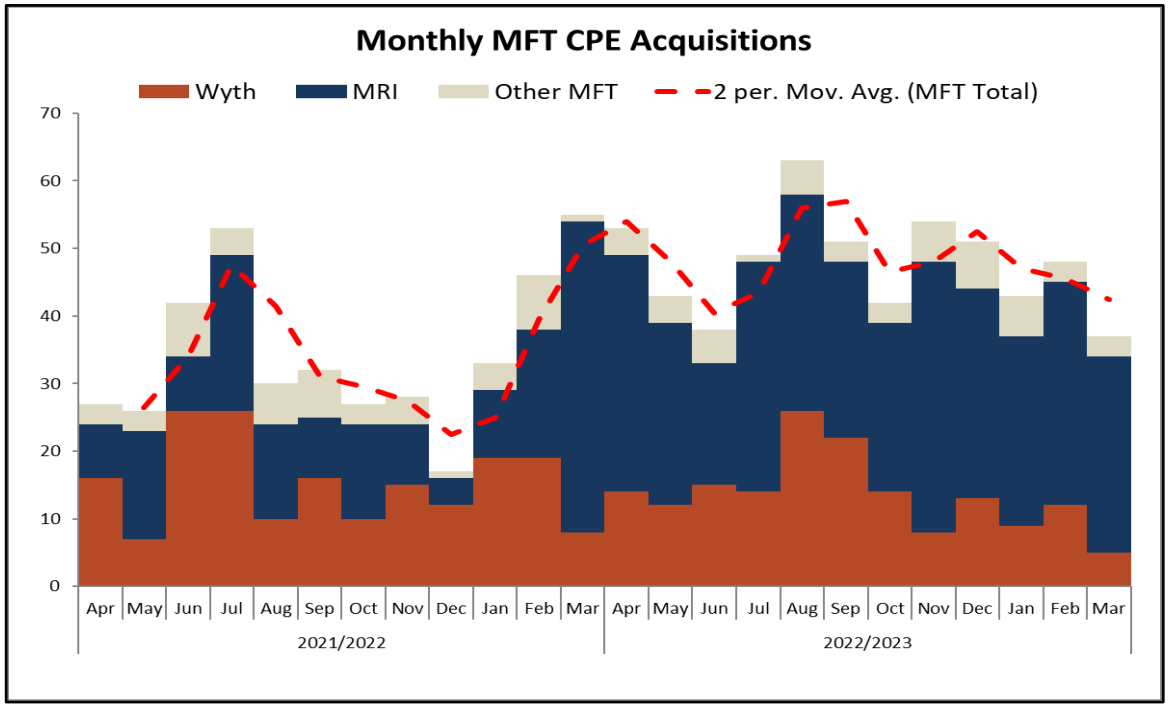


Chart 4: CPE Acquisitions at MFT rolling average indicated by red line

14. Summary of Outbreaks of Infection April 2022 – March 2023

14.1. Outbreaks of Infection (non-COVID-19)

A total of 18 wards were closed or partially closed over 18 occasions due to outbreaks of CPE,ESBL, MRSA and Diarrhoea and Vomiting between April 2022 March 2023. Control measures were implemented and the outbreaks successfully managed.

Table 4 shows the count of CPE cases by Hospital/MCS/LCO
Table 5 shows the count of ESBL cases by Hospital/MCS/LCO.
Table 6 shows the count of confirmed norovirus cases by Hospital/MCS/LCO.

Ward	Hospital/CSU	Date of Outbreak	Number of patientsaffected	Numberof staff affected
MVC/EVC	MRI	15/02/2022	158	0
A9	Wyth	06/08/2022	26	0
Ward 84	RMCH	08/08/2022	4	0
Ward 8	MRI	08/11/2022	15	0
Ward 7	MRI	12/12/2022	7	0

Table 4: Outbreaks due to CPE (April 2022 - March 2023)

Ward	Hospital/CSU	Date of outbreak	Numberof patients affected	Number of staffaffected
Ward 68	St Marys	11/09/2022	12	0

Ward	Hospital/	Date of closure	Numberof patients	Number of staf affected

	CSU		affected	
Ward 5	MRI	03/04/2022	6	0
Delamere	MLCO	08/04/2022	11	1
Ward 8[8]	MRI	11/04/2022	14	0
E3	NMGH	14/04/2022	4	3
Ward 30	MRI	07/01/2023	5	0
Ward 1	MRI	19/02/2023	2	0
Ward 32	MRI	21/02/2023	2	0
Ward 9	MRI	03/03/2023	2	1
AM1	MRI	03/03/2023	4	2
Ward 86	RMCH	23/03/2023	6	0
Ward 82 PHDU	RMCH	24/03/2023	5	9
Ward 85	RMCH	25/03/2023	8	1

Table 5: Outbreaks due to ESBL (April 2022-March 2023)

Table 6: D&V/Confirmed Norovirus(April 2022 - March 2023)

[8] Was a temporary location for MVC

14.2. Manchester Vascular Centre (MVC) CPE outbreak

MVC is a 46 bedded vascular ward providing care for vascular emergency and urgent admissions within the MRI hospital. An outbreak of CPE KPC was identified on MVC in February 2022. There has beenover 200 cases of colonization identified via rectal screening, none of the patients had clinical isolates identified. A suite of IPC measures were implemented including patient isolation, increased screening programme, environmental decontamination and repair of the estate including replacement of all shower waste traps and wash hand basin taps to ensure these were in line with current regulation.

Patients within the unit were screened twice weekly to ensure prompt identification and isolation/cohorting of colonized patients. Patients were screened using PCR testing methodology.

There were challenges in providing side room capacity to isolate all known colonized patients therefore, cohort bays were created to reduce the risk of further cross infection as required.
The CPE outbreak was led by the outbreak control team (OCT) consisting of senior clinical cardio vascular and senior Infection Prevention and Control colleagues. Outbreak meetings were held twice weekly and an action plan instigated.

The MVC unit located on the first floor MRI was relocated to Ward 8 MRI as a temporary measure to ensure completion of remedial works including replacement of shower waste water traps and replacement of all taps.

Despite ongoing management and implementation of a suite of IPC measures there is continued cross transmission of CPE on the MVC/EVC unit, outbreak management meetings continue, with oversight from the GIPCC.

15. Shelford Group Comparison

MFT's performance compared to other members of the Shelford Group can be found in Charts 4 and 6**.** The charts detail the 2022/2023 HCAI rates using KH03 occupied overnight beds data (per 100,000) considering Hospital Onset - Healthcare Associated (HOHA) cases only.

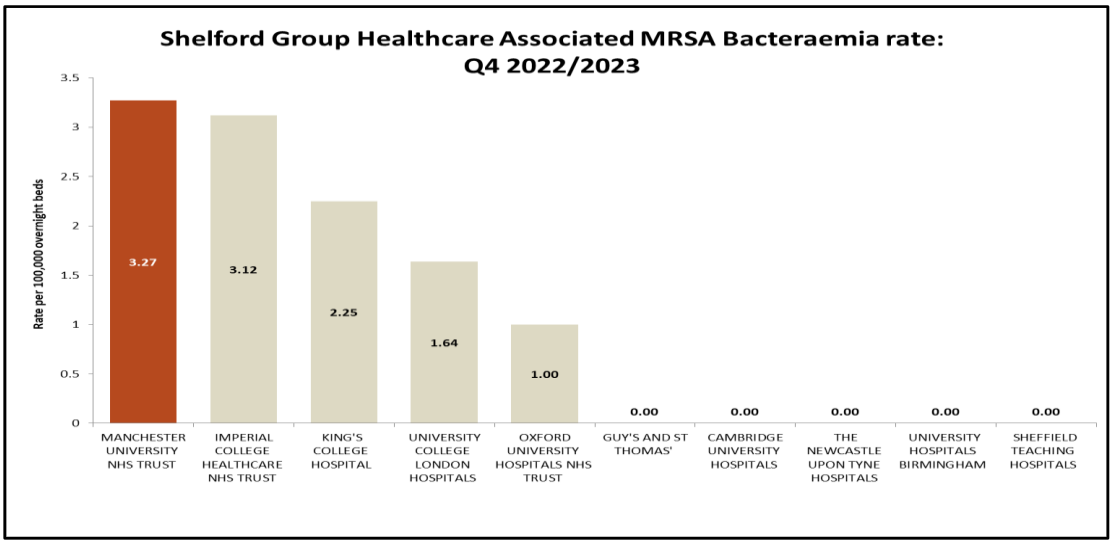


Chart 5 Shelford Group HOHA MRSA bacteraemia rates (per 100,000 overnight beds)

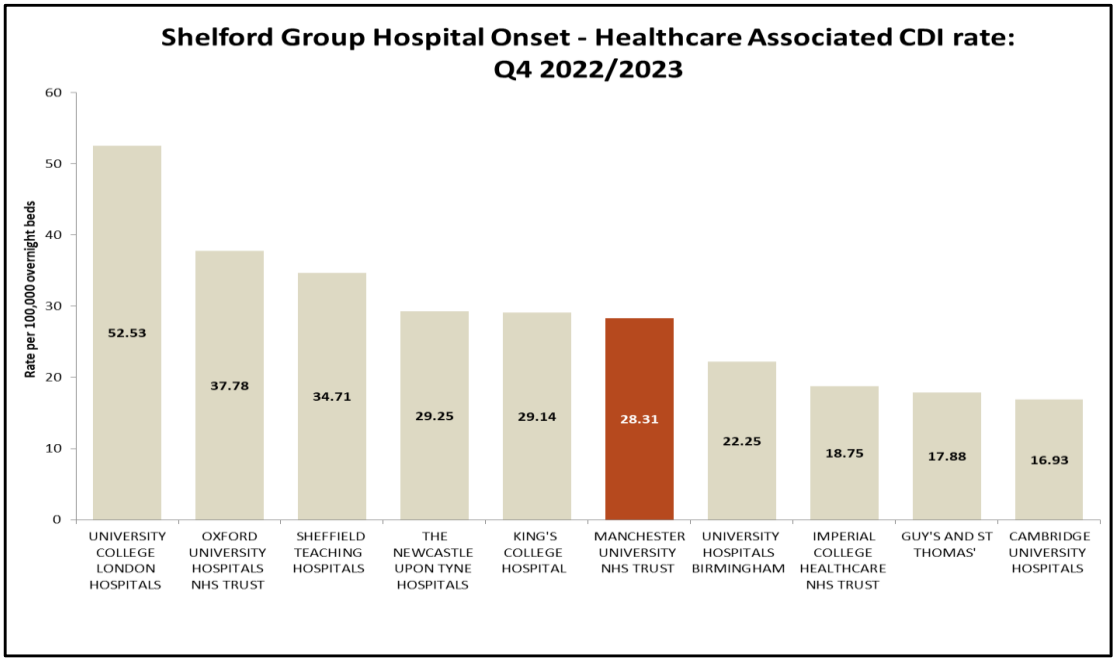


Chart 6 Shelford Group HOHA CDI rates (per 100,000 overnight beds)

16. MFT COVID-19 and Influenza Vaccination Programme

16.1. National Guidance

During 2022 - 2023, the COVID-19 booster and seasonal influenza vaccine programmes were combined in accordance with national guidance and were recognised as an essential activity within the MFT Autumn and Winter Plan.

To ensure the safe delivery of the vaccines, frameworks, policies, a series of standard operating procedures (SOPs) were put in place to support safe delivery of the combined vaccination programme.

Systems were in place to ensure MFT procedures were amended in line with changes to national guidance.

Where agreed locally, NHS Trusts also provided vaccinations to the following:

- Non-trust frontline health and social care workers
- Local communities using the National Booking Service
- HCW clinics to validate MHRA approved vaccinations or provide additional doses

16.2. MFT COVID-19 and Seasonal Influenza Staff & Affiliate Vaccination Programme

The aims of both the staff COVID-19 and seasonal influenza vaccination programmes were to protect employees against debilitating illness, reduce operational impact due to increased sickness absence and the associated costs, and reduce the infection risks to patients.

Final uptake figures for staff seasonal influenza and COVID-19 booster vaccine programmes were published in February 2023.

- Seasonal Influenza vaccine: 50.6% (National 51.8%, Regional 50.3%)
- COVID-19 booster vaccine: 49.4%[9] (National 50.1%, Regional 45.9%)

MFT Vaccine Engagement Group stakeholder feedback was collected to investigate the reasons for low flu vaccine uptake to inform future programme. Reasons for low uptake, included perceptions of flu as being less of risk due to reduced prevalence, and prioritisation of COVID-19 booster (despite offer of vaccine co-administration).

[9] Of those eligible, i.e., had not recently had COVID-19 infection in preceding days, or had not yet received primary course

16.3. MFT COVID-19 and Seasonal Influenza Patient Vaccination Programme

The MFT vaccine service supported training, governance, and systems for:

- Designated Patient Flu areas (during the flu season)

A patient offer was included within the core offer, so uptake for training and local area vaccination was reduced this year.

- 155 Patients received a COVID-19 vaccine
- 152 Patients received an Influenza vaccine

16.4. MFT COVID-19 Healthy GM Population Vaccination Programme

Between October 2022 and March 2023, 3604 COVID-19 vaccines were administered to Greater Manchester residents, supporting a system wide response to improve vaccine uptake, especially in areas of deprivation and previously low vaccination rates.

MFT's system contribution also included the process of significant numbers of validation appointments for staff, patients and the general public, where vaccinations have been administered outside of England or Wales. This contributed to vaccine safety, by ensuring that eligible cohorts can be called and re-called in a timely manner and for the correct vaccine dose in the future.

17. Anti-Microbial Stewardship

17.1. Group Antimicrobial Stewardship Committee

The Group Antimicrobial Stewardship Committee (G-AMC) met in June and October 2022. HIVE implementation and changes to leadership delayed further meetings. In December the Medical Director NMGH, was appointed chair of AMC.

The AMC continue to oversee stewardship activities in line with the MFT AMS vision to:

- Ensure that patients who have an infection are treated with the right antimicrobial, at the right time, at the right dose for the right duration giving the best outcome and minimising harm.
- Work collaboratively with prescribers, pharmacists, lab services, infection specialists, AMC, hospital boards
- Make stewardship everybody's business; working toward local ownership, and leadership across MFT.

17.2. Antimicrobial Stewardship Change Project Group

The Antimicrobial Stewardship (AMS) Change Project Group was established to ensure the AMS vision and strategy was incorporated into the HIVE system, to support clinician's in the use of appropriate antimicrobial therapy. The group collaborated on several workstreams including ensuring AMS prescribing standards were integrated into HIVE workflows, and also featured in system training and that a post go-live KPI strategy could be delivered.

17.3. Extraordinary AMS committee meeting

In September the AMC supported by the HIVE team held an extraordinary meeting and considered the risks and benefits of the 72-hour default duration which has been built for IV antimicrobial infusions in HIVE. A consensus decision was reached that the default duration should remain, to support antimicrobial stewardship, with additional awareness and safety mechanisms, including continuous review. AMC continue to monitor and provide support to clinical colleagues in this change of practice.

17.4. External Visit

In November 2022 MFT hosted a visit from David Webb, Chief Pharmaceutical Officer for England, Kieran Hand, NHSE AMR Prescribing Lead and Diane Ashiru-Oredope, UKHSA AMR Lead, where members of the AMS Group presented the work the Trust are doing to protect patients from AMR. Feedback on the visit was extremely positive

and David Webb commended the ingenuity of the AMC and digital teams in tailoring HIVE to enable antimicrobial stewardship and ensure effective management of infection.

17.5. AMS ward rounds

The AMS pharmacy team continued to focus on patient-centred stewardship activities, with a strong clinical focus on admissions units, targeting AMS and diagnostic stewardship at the “front door”. They also worked with infection specialist colleagues to support the management of complex infections and the use of protected antimicrobials in all areas. The teams flexible approach enabled them to support clinical areas where areas of concern such as outbreaks, were identified.

17.6. Antimicrobial Audit

Antimicrobial prescribing audits were carried out and action plans were put in place to support areas where opportunities for improvement were noted.

18. Maintaining a Clean Environment

18.1. The Role of the Infection Prevention and Control Team

The Infection Prevention and Control Team have worked in conjunction with the Trust Estates and Facilities Teams, Clinical Divisions, Sodexo and internal providers to ensure cleaningstandards are met across the Trust and any changes required following the pandemic were consistently implemented.

18.2. Contracting Arrangements:

The Trust cleaning services were provided by both internal and external contractors/teams.

Sodexo Healthcare are the main contractor for the provision of domestic cleaning services across the Oxford Road Campus(ORC), including the Dental Hospital, and at Wythenshawe Hospital. In addition to the core domestic service following a review of HPV and UVC decontamination Sodexo commenced the provision of these services at ORC and Wythenshawe part way through the year. HPV and UVC decontamination have now been varied into the Sodexo contract and will be provided via the arrangements in place on these sites. This transition has enabled requests for these types of cleans to be carried out more efficiently due the reduction in numbers of parties involved in the process.

North Manchester, Withington, Trafford and Altrincham Hospitals and the Intermediate Care Units all had domestic services provided by in-house teams. As part of the review of HPV cleaning North Manchester continued to provide HPV services through their in-house domestic team. A resource has been provided at Trafford to enable the provision of these services through the inhouse teams.

18.3. National Standards of Healthcare Cleanliness 2021 [10]

The National Standards Healthcare Cleanliness (NSoHC(2021) were implemented following the formation of a multi-disciplinary team. The NSoHC provides a consistent approach to cleaning across the NHS and aims to deliver improvements in cleanliness standards and reporting of these.

Following the adoption of these standards the an Internal Audit was undertaken by the Trust Internal Audit Team, KPMG. The audit specifically reviewed alignment of the Trust’s Cleaning Policy as well as assessing the Trusts cleaning audit and reporting processes to the National standards.

[10] National Standards of Healthcare Cleanliness 2021. NHSE

The audit resulted in an assurance level of 'Partial assurance with improvements required'. While the design of the process adopted provided positive assurance, the process was found to not being consistently operating as designed. A task and finish group has been formed to progress the management actions proposed in the findings of this audit.

18.4. Monitoring Arrangements:

Following the adoption of the NSoHC in 2022 the Trust developed a monitoring schedule to cover all sites. Monitoring is undertaken by trained monitoring officers, employed by Estates and Facilities department and Sodexo. Nursing colleagues join NSoC audits as they are conducted to ensure a multi-disciplinary approach.

The NSoC monitoring regime includes two levels of audits:

- Technical audits,which check and score cleanliness outcome against the safe standard; and,
- Efficacy audits which check the effectiveness of the cleaning at the point of delivery.

Technical audits were carried out regularly in line with the frequencies set out in the NSoC and the efficacy audits were carried out as management audit on an annual basis.

Standards of cleanliness were monitored and reported for all sites through the monthly Quality of Care Rounds, the Ward Accreditation Process, and the What Matters to Me (WMTM) Tracker. These results informed areas of best practice and areas where additional focus was required. Cleanliness metrics were also included for monitoring through the Accountability Oversight Framework.

Systems in place to report and escalate cleaning problems included an agreed process that provided users with information on the level of services to be delivered and expectations, along with information on how to escalate non-compliance or areas of concern.

18.5. Commitment to Cleanliness Charters and Star Ratings

As required by the new NSoHC Commitment to Cleanliness Charters are publicly displayed in all clinical areas, these have replaced the cleaning schedules. Star rating are displayed in all patient facing wards and departments to demonstrate the standard of cleaning delivered on these areas.

18.6. Infection Prevention and Control Training for Domestic Staff:

All new employees attended a generic induction which included the principles of Infection Prevention and Control.

18.7. Patient Led Assessment of the Care Environment (PLACE):

The PLACE assessments were carried out in October 2022 across all of the qualifying sites. These assessments were led by patient assessors and representative from other Trusts as per the national guidance. The Trust achieved an organisational score of 98.72% across the cleanliness domain. This is above the national average which was 98%.

The Trust is running an interim PLACE lite assessment in June 2023, patient assessors will be involved in this process to ensure it replicates the annual submission

19. Water safety

19.1. Management of Risk for Legionella:

Water sampling for Legionella and Control of Legionnaires' disease was undertaken in accordance with COSHH Regulation (2002), Approved Code of Practice L8, Health Technical Memoranda (HTM-04) and Health & Safety Guidance (HSG) 274 across Trust sites. Remedial action was successfully undertaken on outlets that did not meet the required standard.

All building and engineering projects were required to provide additional testing if they included modification or connection to the existing water system, including the need to undertake Water Risk Assessments in line with the above guidance.

Site Water Safety Groups (WSGs) met quarterly to monitor any risks, issues, positive samples, remedial works, reactive works, derogations, and lifecycle works. Issues that required escalation were taken to the Group Water Safety Committee. Water Safety Plans are in place for ORC, NMGH and WTWA and will be reviewed and revised as required in 2023/24.

There is a single Authorising Engineer (AE) for water across the Trust. This role ensured that water safety was managed as consistently as possible. The AE continued to audit the Trust sites and attend site and committee meetings. All sites were audited during the period and several actions were identified.

The audits identified no significant findings of concern, and the E&F teams continue to work to complete the actions to the satisfaction of the AE. Progress against actions will continue to be monitored by site quarterly Water Safety Groups.

In addition, the AE along with the Authorising Persons (APs) across the acute sites implemented monthly 'mini' water safety groups to specifically look at any day to day challenges, actions identified in the AE audits.

On site training of E&F staff was provided by the AE based upon a Training Needs Analysis. The AE developed and agreed Water Safety Training for IPC teams as an appropriate level, this will be progressed during 2023 - 2024. The training will provide understanding of the management of water distribution systems in healthcare facilities and highlight the essential information contained in Health Technical Memorandum 04-01 clearly and concisely.

19.2. Management of Pseudomonas aeruginosa from Water Outlets in Higher-Risk Clinical Areas:

The review of areas classified as Augmented Care for the purpose of sampling for Pseudomonas took place across the ORC, WTWA and NMGH sites and were agreed by the Water Safety Groups. Agreed schedules of sampling for Pseudomonas were produced and sampling continued in accordance with HTM04-01 Part C.

At the request of IPC, Macular Treatment Centres have been added to the list of areas where Pseudomonas sampling is required. This includes two centres based in community premises, where agreement has been made for the landlords to arrange sampling by an independent water testing company. This is being monitored by the Trust EF Compliance Manager for Off Campus/Community Premises.

20. Ventilation

The management of Ventilation Systems was undertaken in accordance with HTM 03-01 Specialist Ventilation for Healthcare Premises and HSG 258; this includes the design, maintenance, and operation of ventilation systems. Where other non-specialised ventilation systems are installed, they are maintained in accordance with manufacturers recommendations and any required standards.

All new and refurbishment schemes were required to provide verification reports, inclusive of commissioning information and any derogations where new systems were introduced or were being connecting to existing plant.

The quarterly site Ventilation Safety Groups (VSG) continued to monitor risks, issues, failed verifications, remedial works, reactive works, derogations, and lifecycle works. Issues that required escalation were taken to the Group Ventilation Committee.

Sites provided assurance that the ventilation in areas where predominately respiratory care is provided, or areas where the Trust may escalate into during seasonal influenza or COVID-19 peaks, met the required standards or there were immediate plans in place to rectify any ventilation below standard.

The performance and reliability of ventilation system to Theatres 1 to 12 continues to be of concern This risk continues to be monitored through Trust Risk Register Assessment, which remains at a score of 12. Until the wider Lifecycle works for the theatres have been completed, mitigating actions and control are in place. Sodexo teams continued to undertake an enhanced maintenance regime alongside more frequent verifications of systems to ensure the theatres could continue to operate. The Deputy Director of Estates ORC continued to liaise with Equans to progress the required Lifecycle works for theatres.

NMGH added a risk to the Risk Register relating to the condition and life-cycling of critical ventilation systems and LEV systems on the site, incorporating ventilation in Theatres. The risk has a score of 12 and is monitored through the NMGH Ventilation Safety Group.

There are no significant risks identified across the WTWA estate, and trend analysis of the aged ventilation plant and infrastructure continued to be undertaken on a quarterly basis to maintain the systems and obviate any issues.

21. Decontamination services

Maintenance and servicing of all the decontamination equipment across the Trust has continued with the active support of our service contractors.

In July 2021, the decontamination services within the Decontamination Services Department (DSD) at Oxford Road Campus (ORC) transferred across to the Hospital Sterilization and Disinfection Unit (HSDU) at North Manchester General Hospital (NMGH) and the Steris facility based in Wythenshawe, to allow the DSD at ORC to undergo a life-cycling refurbishment program which was undertaken through the Trust's PFI Partner, Equans.

The life-cycling program was completed and handed back to the Trust on 22nd March 2023.

Throughout the DSD life-cycle program, all decontamination service provision to the Trust was maintained to an acceptable and satisfactory level.

Sterilisation of reusable surgical devices was undertaken centrally on-site at the ORC in the DSD (temporarily transferred to NMGH in July 2021) and at the HSDU in NMGH. Both Departments are accredited to ISO 13485:2016 (medical devices quality

management system requirements for regulatory purposes) and were reassessed and certified as meeting the requirements of the new UK Medical Devices Regulations during 2022.

An SLA draft for a site-to-site contingency between ORC and NMGH has also been submitted to DSD Management and is pending review and sign off. Sent on the 18.04.23.

Wythenshawe, Trafford, and Withington Hospitals continued in partnership with The Christie NHS Foundation Trust and Warrington and Halton Hospitals NHS Foundation Trust to receive their sterile services provision from Steris, the independent decontamination services provider, from their facility in Wythenshawe. This was monitored by the Wythenshawe, Trafford, Withington & Altrincham (WTWA) Estates & Facilities Decontamination Group and through Positional Reports provided by the Contract Manager.

The Endoscopy Services, across the Trust continued to provide satisfactory, compliant, and accredited levels of service to all sites. All Endoscope Decontamination Staff are fully trained and competent with all new systems and processes (verified as part of the JAG Audit and the Independent Authorising Engineer (Decontamination) (AE(D) Institute of Healthcare Engineering and Estates Management (IHEEM) Annual Compliance Audit process). Accreditation remains in place with the Joint Advisory Group (JAG).

All Endoscope Washer disinfectors and Endoscope Drying Cabinets were regularly tested and validated accordingly. Currently there is a replacement program for all the Wythenshawe Hospital Endoscope Drying Cabinets which is ongoing and managed by P&ED.

The Wythenshawe Endoscope Decontamination Department has had a full refurbishment and upgrade program of works during 2021 / 2022 with the project being successfully completed in April 2022.

The new Getinge electronic tracking and traceability system (TDOC) for all flexible endoscope decontamination process across MFT was completed in December 2022 following significant investment. The overall project was successfully managed by the MFT Informatics Service.

In the community premises, decontamination is confined to the community dental practiceswhere instruments are processed through benchtop sterilisers. Assurance was received through scheduled engineering testing and maintenance managed by WTWA Operational Estates.

The Group Risk for Decontamination MFT/002842, which identified seven workstreams will be reviewd by GIPCC in April 2023, with a view to reducing the risk to 12 from 16, acknowledging the progress made in mitigating the risks associated with Decontamination across the Trust.

22. Training and Education

22.1. Respiratory Protective Equipment (RPE) Training

In accordance with the requirements of the IPC Board Assurance Framework (BAF) localHospitals/MCS fit testing records were locally maintained on the central learning hub, the fit testing competencies are now uploaded onto the national electronic staff register (ESR)

As part of the COVID-19 pandemic response NHS supply chain and Ashfield Engage partnered to provide organisations a free FFP3 fit testing service. Ashfield Engage provided 5WTE fit testing staff to support the existing FFP3 fit testing provision within MFT. The Ashfield Engage fit testing support ended on 31st March 2023.

There is an ongoing requirement for all healthcare staff who are required to use FFP3 within their role to be fit tested every two years to at least two different masks to ensure there is no over reliance on a particular brand of mask.

The IPC Team have recently updated a video for donning and doffing of RPE which forms part of a mandatory training module requiring staff to watching the video and then undertake a self-assessment. Results are recorded on the learning hub.

22.2 The Infection Prevention and Control Development Pathway (IPCDP)

The Infection Prevention and Control Development Pathway (IPCDP) was commissioned in 2020 by Greater Manchester IPC Leads and overseen by the Chief Nurse at MFT.

The pathway is delivered at three levels Foundation, Intermediate and Advanced, and focuses on knowledge, skills and behaviour with an emphasis on changing behaviour and assisting others to do this. It is an interactive e-learning package with personal and professional development activities throughout the programme.

Additionally, the pathway is aligned with a knowledge, skills and behaviours framework, allowing individuals to assess and plan their professional development linked to IPC. This, in turn is aligned to NHS Knowledge and Skills framework (KSF), Infection Prevention Society (IPS) and World health Organisation (WHO) competencies.

The Foundation level of the pathway was initially available to IPC practitioners and healthcare workers across the Northwest, including MFT.

Following successful development at MFT, the Pathway was launched to a National cohort of 160 new IPC practitioners by Sue Millward, Clinical Lead for IPC NHSE on 20th July 2022. Duncan Burton, Deputy CNO and Lisa Richie, Head of IPC, NHSE delivered welcome messages to the new participants and an overview was presented by MFT Chief Nurse, Professor Cheryl Lenney OBE.

Whilst undertaking the pathway, participants were supported by a buddy system led by national and regional leads.

There was a collaboration event to close the cohort on 7th December. Feedback from this was extremely encouraging and participants had learned a great deal from the pathway and highly recommend it. Due to difficulties with allowing study leave nationally this completion date was extended to 31st March, and subsequently, 30th June 2023 to support individuals to complete.

Table 7 below details total numbers of participants enrolled and their progression with each of the pathways:

Foundation Pathway		
	Internal	External
Enrolled	402	342
Not started	139	41
In progress	150	118
Completed	113	183

Intermediate Pathway		
	Internal	External
Enrolled	85	158
Not started	47	26

In progress	15	21
Completed	23	111

Advanced Pathway		
	Internal	External
Enrolled	10	156
Not started	3	50
In progress	4	10
Completed	3	96

Table 7: Enrolment on the ICP Development Programme 2022 -2023

23. Implementation of the EPIC system HIVE September 2022

Hive EPR is an integrated electronic patient record providing the ability to document care, place orders, prescribe and administer medications, support patient flow. It also provides specialist functionality for some areas, for IPC the module is BUGSY. All modules work together for a seamless system.

The Hive `go live` period with identified command and control plans were stepped up on the 8th of September 2022, lasting for approximately 6 weeks, along with a rigorous command centre governance structure. This ensured safety issues had a management approach through the Nursing Midwifery and Allied Health Professional (NMAHP) governance structures, including Chief Nurse/DipC oversight.

A Rapid Decsiion Group (RDG) consisted of senior IPC team worked alongside developers to inform the BUGSY build and future potential requirements of the system.

Additional training for Mental Health First Aiders, increased capacity for Wellbeing Conversation training, induction support for Floorwalkers and Superusers, together we can Thrive with Hive was made available in the Wellbeing Pack. Ongoing engagement continued with Staff Side to support Go-Live and workforce transformation.

The IPC/TV team identified several `superusers` to support the implementation of BUGSY. They attended `Wellbeing & Resilience` workshops with Bailey & French September 2022. The training sessions increased the level of support they could provide to the team through the period of change, as well as ongoing reporting of issues to the HIVE team (by raising IT tickets and regular meetings).

Hive go live staff engagement sessions with the senior CSS leadership were held in September and October 2022. A business continuity policy was completed, with a Tabletop Exercise taking place 22nd of August 2022. As part of the plan, an IPC/TV 'Red folder' contingency plan was created which included an IPC aide memoir for patient care.

A supporting policy `Standard Operating Procedure for the Chief Nursing Office NMAHP Hive Command Centre` published September 2022, this was supported by a daily sit rep for completion before 12:30 each day by relevant leads which included the IPC/TV specialist team.

There were approximately circa 300 Floor Walkers across MFT. Floor walkers were available, mainly external to MFT staff via other UK Epic sites and Epic themselves. The IPC/TV team ensured daily walkabouts throughout each hospital site assisting staff to navigate the system specific to the speciality, as well as internal support to the team
Go live occurred on the 8th September2022. The IPC/TV team began raising `Bugsy tickets` and liaised closely with the Hive team to ensure any issues or gaps could quickly be resolved from September onwards. Issues raised, discussed at meetings and resolved included;

GP letter templates added to HIVE in October 22. To enable communication about patients with a new infection status.

The infection control daily alerts were discontinued due to the delivery of new results directly to the clinical teams caring for the patient. The 'Daily Alerts' were replaced by a dashboard visible to the IPC team, where detailed reports were also added for monitoring purposes.

Integrated Care Plans, for example MRSA were added to flow sheets, which worked better than where they were initially within the 'Notes' section as a template. Working with the HIVE team meant that this was a much-improved user-friendly method in several aspects of both IPC and TV related.

- Changes were made to IPC and TV induction education to include HIVE documentation to ensure timely and accurate documentation.
- The IPC team are now able to run outbreak reports and create area/infection specific reports for monitoring and surveillance.
- Initially it was found that there were multiple tabs to record a completed a skin check, tickets were raised with IT, and the HIVE team responded promptly to ensure it was streamlined to one 'pressure ulcer management flowsheet', which contained the appropriate information in one place.
- The pressure ulcer risk assessment plan was reviewed and changed to the `Purpose T` instead of the usual `Waterlow` scoring system. eLearning Education was provided prior to going live about purpose T and a recorded system demo on how to complete was shared across the trust.
- An `order` process was created which allowed the TV nurse to advise the use and ordering of Larval or negative pressure wound therapy. This enabled the 'prescription' of treatment to be recorded and for the task to be added to the clinical staff task list as needed.
- Changes were made to the 'inpatient consult to tissue viability' to ensure that patient referrals or consults were being received by the Tissue Viability Team and that patient information was included.
- The Tissue viability team worked to set up folders to allow to utilise HIVE for the triage, review, assessment and follow up of patients in each hospital.

The Hive stabilisation period ran from January to March 2023, where processes were standardised, and critical safety changes were made toward supporting the business-as-usual processes.

24. End of Year Reviews

The Chief Nurse/DIPC undertook a robust end of year IPC review with each Hospital/MCS/ LCO during March 2023. The review meetings were held individually with the Directors of Nursing, supported by their Senior Team and local Infection Control Doctorand IPCN(s). The review panel was led by the Chief Nurse/DIPC supported by the Associate Medical Director for IPC and the Assistant Chief Nurse IPC/TissueViability**.** The sessions were an opportunity to reflect and focus and feedback was very positive from all those involved. Common themes to emerge included:

- Low level compliance with Trust screening/isolation policies particularly in clinical areas where there are insufficient isolation facilities
- Low level compliance with IPC principles,
- Lack of consistent engagement with some professional groups in the IPC agenda

The Hospital/MCS/LCO leads are reviewing and updating their local IPC action plans andwill report to the Group Infection Control Committee on outcomes.

The Hospital/MCS/LCO teams were supported to prepare and attend the review by a named IPC Nurse and Infection Control Doctor. A summary of all the reviews can be found in Appendix 3.

25. Conclusion

12. The Annual Report demonstrates the response to the first year of recovery following the COVID-19 pandemic. It evidences the commitment, dedication, and hard work of all staff at all levels of the organisation to work together to achieve safe standards of patient care as we resumed business as usual activity.

    As this report demonstrates, there is no room for complacency. To maintain patient safetyand reduce the risk of infection it is essential to continue adherence to IPC practices by all members of staff. It is imperative that the learning identified from incidences of healthcare acquired infections, outbreaks, audits and cross site information analysed through the governance proceses in place, is embedded in practice.

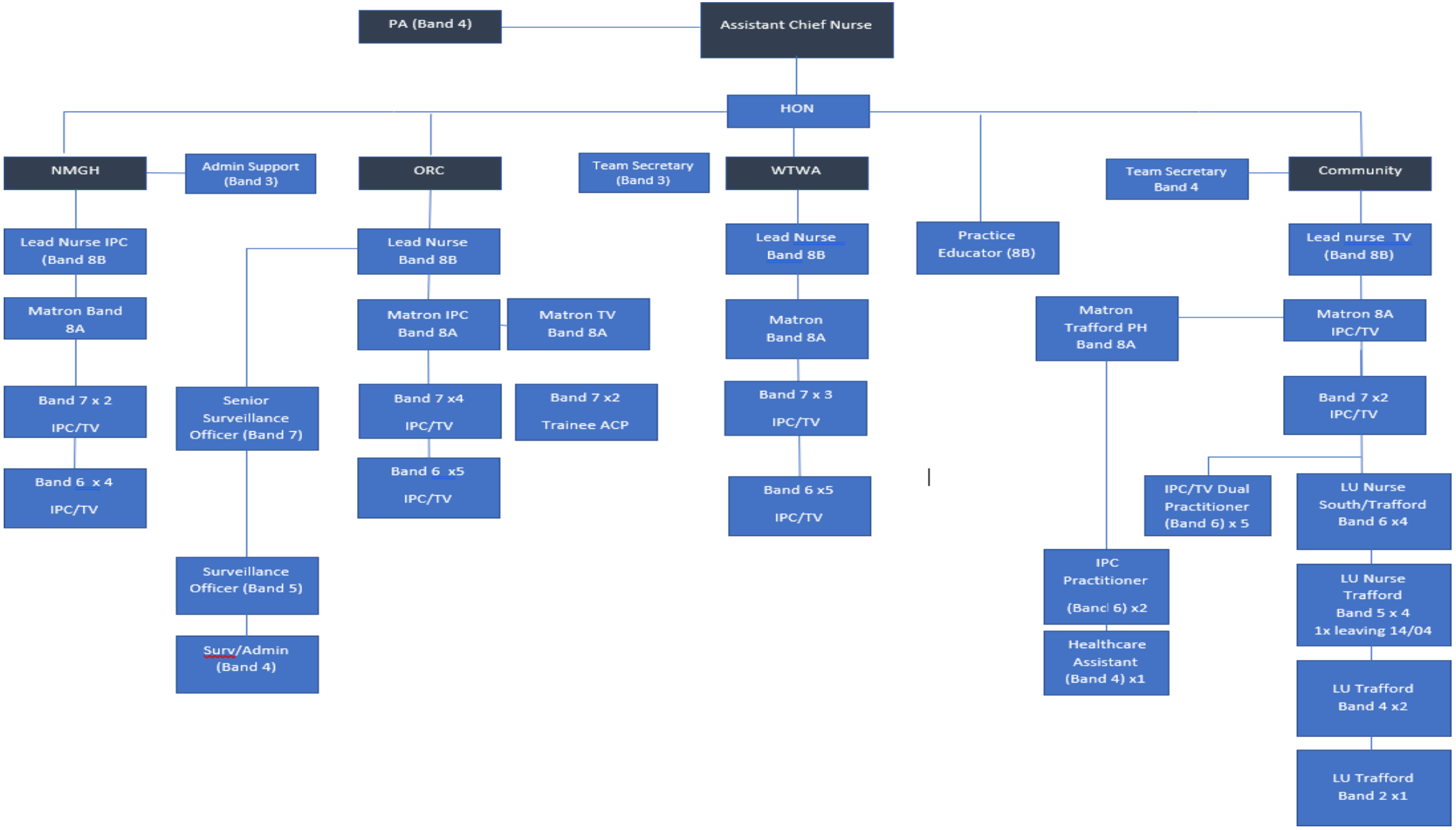
    The Trust would like to acknowledge the contribution of all staff across all disciplines, including volunteers and patients in supporting efforts to prevent, control and manage infections.

26. Recommendations

The Board of Directors are asked to:

- Note the information provided in the Executive Summary, and
- Accept the Infection Prevention and Control Annual Report for 2022/23

Appendix 1 MFT IPC/TV Nursing Team Structure 2022/23



Appendix 2

GROUP INFECTION PREVENTION & CONTROL COMMITTEETERMS OF REFERENCE

i.CONSTITUTION

The Group Management Board has established a Committee to be known as the Infection Prevention and Control Committee. The committee is an executive committee and holds the powers delegated to it in these terms of reference. The Infection Control Committee is chaired by the Chief Nurse/ Director of Infection Prevention and Control.

ii. MEMBERSHIP

1. Membership shall consist of:

Chief Nurse/DIPC (CHAIR)
Associate Medical Director (Infection Control)
Group Deputy Chief Nurse
Assistant Chief Nurse, IPC & TV
Consultant Virologists
Directors of Nursing
Head of Nursing IPC
Lead Nurses Infection Prevention and Control
Hospital/MCS Clinical Leads for Infection Control
LCO to Hospitals/MCS
Consultant in Communicable Disease (Public Health England)
Lead Antimicrobial Pharmacist
Director of Estates and Facilities
Assistant Director, Employee Health & Wellbeing
Chair of Antimicrobial Committee

All group executives have an open invitation to and may attend committee meetings

2.2 No business should be transacted at the meeting unless a minimum of ten members are present, which must include the Chair or Deputy Chair, four Hospital Clinical Leads, and either the Group Deputy Chief Nurse or the Assistant Chief Nurse

iii. ATTENDANCE AT MEETINGS

1. The Infection Control Committee may require the attendance of any Trust employee (or agent of the Trust)

iv. FREQUENCY OF MEETING

1. The Committee will meet every three months (four times a year) but may be convened at other times as deemed necessary.

v. OVERVIEW

1. The Committee will set the strategic direction for infection prevention and control and seek assurance on an exception or as required basis

2. The Committee is responsible for developing the group organisational strategyand clinical standards for infection prevention and control in line with national/iternational evidence-based practice and standards.

vi. SCOPE AND DUTIES

1. Provide strategic leadership for infection prevention and control, including identifying priorities and setting performance targets.

2. Develop the strategy and agree the clinical standards for infection preventionand control across all the Trust sites.

3. Approve the programme of work of the Trust Clinical Infection Control committee.

4. Receive Hospital/MCS ICC performance and exception reports.

5. Receive, review, and ratify group policies, clinical pathways, and reports, including the Annual Infection Control Report.

6. Approve the annual audit calendar to provide assurance that standards are met and any required changes to practice, systems and processes are delivered.

7. To report to the Group Management Board on performance against infection control indicators and audits, including actions taken to address any areas for improvement.

8. To determine and commission programmes of work required to deliver the work programme of the Infection Control Committee.

9. Oversee the Trust's involvement in and response to, internal and externalassessments and inspections.

10. Agree the education and training framework for infection prevention and control for the Trust, ensuring compliance with infection prevention and control standards.

11. Approve the Trust's Annual Infection Control Report.

12. To describe, review and monitor the principle and significant risks related to infectioncontrol on behalf of the Trust and present these with the plan of controls to the Group Management Board and Risk Management Committee.

13. The Infection Control Committee will receive exception reports from the Hospital/MCS Infection Control leads where performance is out with the standards set out in the IPC strategy.

14. The Infection Control Committee will receive at each meeting a report from the TrustInfection Control Group to include:

    a. Policy and pathway development
    b. Infection Control Group activity

c. Changes to national or local strategy
d. Trust wide themes identified from adverse events

vii. AUTHORITY

1. The Infection Control Committee is empowered to examine and investigate any activitywithin the Trust pursuant to the above scope and duties.

viii. REPORTING

1. The Committee will report to the Group Management Board.

2. The Committee will work closely with relevant Group Committees and the Clinical Advisory Committee and will provide assurance to the Board of Directors in relation to infection prevention and control

3. The minutes and exception report (as required) will be considered at the next RiskManagement Committee and Quality and Performance Scrutiny Committee

ix. REVIEW

1. These terms of reference will be reviewed annually.

x. KEY PERFORMANCE INDICATORS

1. These Terms of Reference will be measured against the following key performance indicators:
2. 75% attendance of all listed members or nominated deputy
3. Presentation of the Annual Infection Control Report.

Appendix 3

Overview of End of Year Reviews

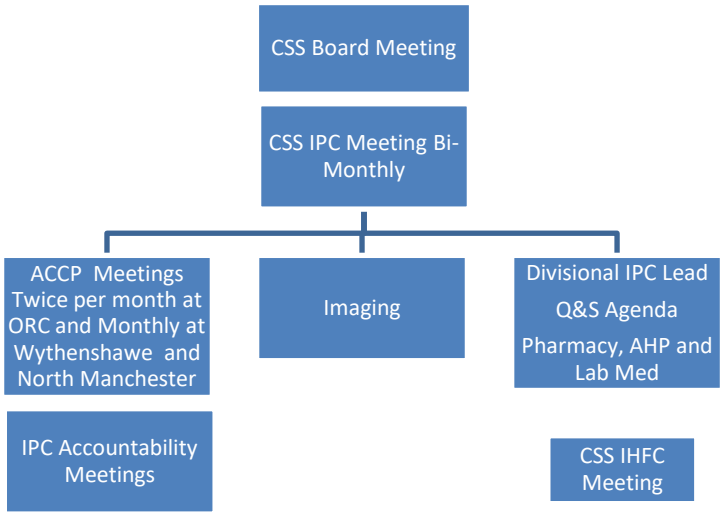
Hospital/MCS: Clinical and Scientific Services (CSS)
Date: April 2023

Summary:

Framework for IPC

- **Director of Nursing; Clinical Lead, IPC; Lead IPC Nurse(s); Lead Infection Control Doctor**
- **Framework for Hospital IPC meetings**
- **Record of attendance at all meetings**

- **CSS Infection Prevention and Control Meeting-** held bimonthly and chaired by the Clinical Director for Anaesthetics, Critical Care and Peri-operative care (ACCP) and Director of Nursing with attendance from all disciplines, IPC representative and Microbiology/Virology colleagues.
- **Divisional IPC Meetings-** Meetings held at divisional level either biweekly or monthly attended by Lead Nurse for IPC and Critical Care consultant. Learning from these are shared across the divisions and also via the ACCP board.
- **Division of Imaging-** Monthly divisional IPC meetings held. Minutes and actions are reported via Imaging Quality and Safety meeting. All Imaging sites have an IPC champion and are now included in the MFT monthly hand hygiene audit, 35 areas are now included in the audit.
- **Remaining Divisions-** Including Pharmacy, IPC, Directorate of Laboratory Medicine (DLM) and Allied Health Professionals (AHP) have IPC focus groups and undertake audit and share information within their teams via the local Quality and Safety agenda.
- **Accountability meetings-** There were 4 accountability meetings held in 2022/23, with 1 pending. Details of learning and actions from these are detailed in section 2, Healthcare Associated Infections. In July 2022 it was agreed that a monthly accountability meeting would be scheduled to assist in diary planning. Meeting invites have been sent to all required personnel however there have been a number of meetings postponed due to lack of attendance from essential personnel resulting in a backlog of cases for review each month. The CHD for ACCP is seeking to address this with the relevant specialists.



Healthcare Associated Infections

Healthcare associated infections are reviewed by the Critical Care Unit Matrons. Findings and lessons learnt are shared at local IPC meetings and summarised at the CSS IPC meeting.

- There has been an increase of GNBSI during 2022-23 with 55 reported, compared with 40 in 2021-22. Whilst this remains within the AOF threshold of 57, the GNBSI action plan continues to be used as a tool to monitor progress and improve practice.
- MRSA bacteraemia review identified lapses in care relating to a delay in blood culture sampling and failure to document the collection on HIVE.
- VRE bacteraemia review identified lapses in care relating to sampling and seeking assistance to undertake procedure. Also noted that HIVE does not allow documentation of ANTT, this has been escalated to the HIVE team.
- There have been no Periods of Increased Incidence (PII) of *Clostridioides difficile* (CDI) compared with 3 periods during 2021-22
- Senior Imaging staff attended an MRSA bacteraemia meeting, to ensure any lessons learned could be fed back within the division, which was arranged by Ward F7 Wythenshawe Hospital as the patient had attended Radiology for line insertion.

Respiratory Viruses

COVID-19

During 2022/23 there have been 123 patients admitted to the Critical Care Units with Covid-19 diagnosis. The majority of admissions have been to the ORC Critical Care Unit.

- There have been 12 Hospital Onset Covid Infections (HOCI) during this time period (7 ORC, 3 CTCCU, 2 AICU).
- Investigation of these has identified lapses in screening protocols, primarily with a delay in sending admission screens prior to Critical Care admission.

Influenza

During 2022/23 there have been 60 patients admitted to the Critical Care Units with seasonal Influenza. The highest number of admissions were on the ORC Critical Care Unit.

Outbreaks of Infection

During 2022-23 there have been 4 outbreaks of infection across the critical care units. Outbreak meetings were held in line with IPC policy and actions implemented to focus on IPC practices including;

- increased hand hygiene audits
- environmental inspections with Sodexo colleagues
- use of the light box
- stethoscopes and tympanic thermometers procured to ensure one for every bed space,
- re-design of the nurse in charge IPC forms to ensure pro-active completion rather than re-active
- review of UV scheduled cleans in common areas
- introduction of Chlorclean wipes for patient shared equipment
- participation in the Sink Bug Study.

Compliance with IPC Clinical Practice

The Critical Care Units have re-vamped the ‘Commitment to Infection Control’ document following a number of lapses in hand hygiene and PPE use amongst visiting teams. The new Commitment will be launched in April 2023 the CHD for ACCP is taking the lead to circulate this to all clinical teams across MFT who interact with the Critical Care Units.

Patient Safety Focus for March has been ‘IPC ’ to further promote exemplary IPC practices amongst staff. This has been done utilising bitesize education tools, quizzes, key messages at handover, use of the light box.

A Lead Nurse has been identified as the Lead IPC Link Nurse for Critical Care and is driving forward with the development of the link nurse roles and responsibilities across the units including promoting the ‘Gloves Off’ campaign.

Hand Hygiene and Personal protective equipment (PPE) audit data

- Only 5 areas of imaging are consistently submitting HH and PPE audit data each month. This continues to be a focus for the Imaging Matron and Senior Clinical Teams as these impacts disproportionately on the Imaging AOF
- In Feb 23 all Critical Care Units submitted their HH and PPE data however some units used the old electronic link to access the proforma and therefore their results were not included for that month. The Unit matrons have addressed the issue of the wrong link and continue to monitor the audit results and improvement plans.

Aseptic Non-Touch technique (ANTT) and FFP3 fit testing

- Oversight and monitoring of ANTT and Fit testing within nursing and AHP disciplines is thorough and well managed.
- Monitoring of medical staff compliance remains challenging. The new Kallidus Learning Hub will enable more thorough and robust management of medical staff compliance with ANTT.

CSS Priorities for 2023/24

- Continue to prioritise IPC standards of practice to reduce the risks of HCAI.
- Continue to support staff wellbeing including promotion of vaccinations for Influenzas and Covid-19.
- Support trust initiatives to improve IPC Practice across the organisation.
- Improve monitoring and management of compliance with ANTT and Fit Testing across all staff disciplines.
- Improve HH and PPE auditing across all areas to ensure high standards of compliance.

Hospital/MCS: North Manchester General Hospital (NMGH)
Date: April 2023

Summary:

Framework for IPC

- **Director of Nursing (DoN); Clinical Lead, Divisional and Corporate Heads of Nursing, Lead Nurses, Deputy Medical Director, IPC Matron and Lead Nurse, IPC doctor, Directorate Manager for AHPs (AHP Clinician) Estates and Facilities Matron.**
- **Framework for Hospital IPC meetings**
- **Record of attendance at all meetings**

- **NMGH Infection Prevention and Control Meeting-** IPC meetings monthly and has associated action log which is reviewed at the monthly meetings. The committee reports into NMGH Quality and Safety forum, which receives minutes and items for escalation. Minutes of the hospital meeting are overseen at Group Infection Prevention and Control Committee (GICC)
- **Outbreak meetings**- A thrice weekly outbreak management meeting scheduled as a standing rolling forum which is linked with the operational management of the site. This is led by the DoN/DDoN to ensure that there is clinical IPC oversight and support of issues and decisions to support patient flow
- **IPC subgroups**- The flowing reports are received at the NMGH IPC committee

NMGH Cleaning Committee report
Catering Report
Estates & Facilities Report
Water Safety Group & Legionella report
Decontamination Committee report
Ventilation Theatres/Endoscopy report
Antimicrobial Pharmacist report

Healthcare Associated Infections

Healthcare associated infections are reviewed by the clinical Lead Nurses and Matrons Findings and lessons learnt are shared at local IPC meetings and summarised at the NMGH IPC meeting. The following are some of the issues identified throughout the root cause analysis (RCA) process

- GNBSI- delays in sampling, omissions in daily PICC line documentation, Catheter management and cannula management.
- MRSA bacteraemia- review identified IV/PICC line management, delay in administering decolonisation therapy and delay in administering intra venous antibiotics
- CDI- antimicrobial stewardship, delay in obtaining a sample and documentation of antibiotic review date.

In response to the above findings the following actions were taken

- Communication campaign around IPC fundamentals of care
- Implemented an IPC fundamentals of care checklist
- Increased ANTT education and assessment
- Implemented GNBSI improvement plan focusing on improvements in hydration, IV-line care, Hand Hygiene, developed nutrition and hydration forum which is driving through the campaigns
- Delivered antibiotic stewardship campaign with strong medical leadership, MD and DMD
- Introduction of Hive reporting urinary catheter to drive reduction catheter days
- Catheter care improvement work with support by IPCC
- Sepsis management improvement work part of the quality improvement work
- Divisions have mandatory training improvement plans in place
- Introduction of Hive reporting cannula >4 days to reduce cannula days
- Ward based IPC champions

- Staff training for PICC line and CVAD management.
- Focus on Fundamental Standards
- Improvement plans in place to deliver ANTT standards

Respiratory Viruses

COVID-19

During 2022/23 NMGH reported 1811 COVID-19 cases. Of those cases;

- 349 (19.3%) cases being classed as nosocomial infections
- 129 (37%) probable Healthcare Associated (day 8-14 following admission)
- 220 (63%) definite Healthcare Associated (day 15 following admission)

The remainder of cases were reported as being community acquired (acquired prior to day 8 of admission)

Outbreaks of Infection

Learning from respiratory virus outbreaks is achieved at thrice weekly outbreak meetings and includes;

- 100% of outbreak areas completed Fundamental Standards Checklist, reducing the risk of transmission of COVID-19 infection, both from staff to patients, patients to staff, and patient to patient.
- 100% of outbreak areas had enhanced cleaning implemented on the day.
- There has been Increased focus on staff vaccination and adherence to PPE and HH guidance.
- Maximising segregation of personal care facilities (toilets and washrooms).

Compliance with IPC Clinical Practice

Hand Hygiene/PPE and FFP3 fit testing- observational audits continue to monitor the standards of IPC compliance on wards and departments. All wards and departments have staff who are fit tested to FFP3 masks

Water safety- reports received by NMGH ICC- compliance with water safety regulations met, all sterilisers and washers has now been transferred to the MFT network ensuring all cycles are now backed up on the MFT server to deliver compliance assurance

Ventilation safety- reports received by NMGH ICC-compliance with ventilation safety met

Decontamination services- quarterly reports received by NMGH ICC- internal audits are timetabled, there is monitoring of any items undergoing manual washing ahead of sterilisation, no concerns escalated, and the risk profile remains unchanged.

There is a structural gap in training and assessment across the NMGH site, except for Emergency Department (ED) and theatres there are no practice-based educators on site.

NMGH Estate Issues

Site wide issues

- There are a variety of Nightingale ward bed numbers which range from 10 to 17 beds
- The patients are nursed in one open bay with partitions.
- Side rooms are limited within the wards only 1 or 2 per ward.
- Bioquell and Clinell pods are available on site
- The footprint of ED has been challenging for maintaining IPC standards.
- 'Biopods' have now been fitted within resus area to provide patient segregation during aerosol generating procedures (AGP)
- The respiratory ward I6 has 5 Bioquell pods installed to manage segregation during AGP procedures

Theatres 5&6

- Theatres 5 & 6 were closed Nov 2022 to Jan 2023 due to a deterioration/mould in the environment caused by leaks from the steam system beneath the building.
- Affected ceiling tiles were removed and environmental plating completed, all affected stock removed.
- The area was cleaned, and ventilation validation undertaken.
- Theatre 5&6 were reopened following the return of satisfactory results in January 2023 however the staff room remains out of use whilst external works resolve the issue.
- All staff underwent risk assessment and referral to Employee Health and wellbeing if required

Antenatal clinic

- St Marys Hospital antenatal service based on the NMGH site was relocated due to visible mould on the walls and ceilings following heavy rain fall and roof leakage.
- There were very high counts of mould in areas sampled.
- The roof cavity was also suffering from interstitial condensation.
- Immediate action included risk assessments for all staff and patients and providing antenatal services for immunocompromised patients outside of the existing antenatal clinic footprint
- Whilst identifying an alternative are to provide ante natal services priorities included clearing the flat roof, steam link isolation, industrial dehumidification, monitoring daily temperatures and humidity readings to check environmental conditions.

Hospital/MCS: Royal Manchester Children's Hospital
Date: April 2023

Summary:

Framework for IPC

Director of Nursing (DoN), Clinical Lead, Deputy Director of Nursing and Divisional Head of Nursing, Lead Nurses, Matrons, IPC nurse and IPC doctor, Pharmacist and Line specialist nurse.
Record of attendance at all meetings
RMCH Infection Prevention and Control committee (ICC) meeting- ICC meetings held bi-monthly and are chaired by the DoN with a focus on risk and assurance. The ICC reports to the Hospital Management Board and Group Infection Control Committee (GICC) on a quarterly basis.
Outbreak meetings- Outbreak management meetings are held as required and led by the DoN/DDoN and attended by the clinical teams, IPC representative, Estates and Facilities and Sodexo representatives.
Further IPC governance meetings include;
Healthcare associated infection (HCAI) accountability meetings
IPC Key Performance Indicator meetings

Healthcare Associated Infections

The highest increase of HCAI in year has been CPE Acquisitions, the increase in incidence has been seen across a number of clinical areas rather than focused to one area. The rise has also been reported Nationally in the young and elderly in particular. All cases of HCAI of CPE have been reviewed in Infection Control Key Performance Indicator (IPC KPI) meetings with a focus on screening process, hand hygiene and environmental cleanliness. Positively, there has been no increase in CPE Bacteraemia providing assurance in vascular device practices.
The largest decrease in HCAI has been in VRE Acquisition, this has occurred following significant environment improvements in haematology/oncology with a move of wards providing an increase in cubicles for the speciality, alongside extensive teamwork with IPC Team and Sodexo to ensure the environment is maintained. There has been a recent period of increased incidence in VRE in oncology (October to December 2022), this was further to a drop in screening of high risk patients on admission following the implementation of HIVE, once screening was re-implemented a cluster of patients were identified. The incidence has reduced again from January 2023.
Gram Negative Bacteraemia continues to be the highest incidence of reportable HCAI, the majority of these cases are in Haematology and Oncology patients, and following review in IPC KPI, are concluded unavoidable, with a cause of mucosal barrier injury as a result of periods of prolonged neutropenia being concluded in patients receiving chemotherapy for haematologic malignancy. Whilst this is the main cause concluded, all cases are still heard to ensure practice standards are being achieved.

Respiratory Viruses

Respiratory Virus Incidence has been higher than average throughout the year with loss of seasonal trends. Cases have converted to admissions in both observation and assessment (O&A) beds and critical care beds with surge beds being required during peak times, this has required an increase in nursing ratio in secondary paediatric areas from the recommended 1:4 to 1:6 which is in line with the Safe Staffing in Extremis Guidance.
Hiflow/Airvo in RMCH has previously been provided only in the high dependency unit (PHDU) except for individual long-term cases in Ward 85. The pressure on critical care services in 2022/2023 has required a review of this practice with a move to stabilised patients on Airvo being managed in their speciality areas when it is appropriate to do so. Guidance and training have been updated to support the teams to deliver Airvo in the ward areas.
Management of cubicles to achieve the required isolation is requiring 2-3 times a day reviews by Matrons and Lead Nurses to ensure cubicle utilisation is optimal, this is supported by IPC, with risk assessments and use of cohort bays being required in most clinical areas at peak times.

Outbreaks of Infection

During 2022/23 there were 9 outbreaks of infection across RMCH COVID-19 (4), Norovirus (3), VRE (1), CPE (1). In each incidence an outbreak meeting and IPC huddles have been co-ordinated to review cases and spread within the clinical area with representation from ward teams, Divisional Matron and Lead Nurse, IPC nursing team, microbiology and Sodexo, with rapid actions agreed achieving early recognition and avoidance of further spread.

Learning from Outbreaks

The introduction of HIVE saw a reduction in compliance with standard screening practices for CPE, MRSA and VRE as this was predominantly led by nursing assistants pre-HIVE, post HIVE they were no longer able to request samples and the process was initially lost. As processes were re-established an increase in cases were identified that then were classified as HCAI, these were patients who had not been isolated and therefore in Ward 86 where there is a high proportion of patients with length of stay of one week or more, a cluster of patients developed particularly for VRE and CPE.
Relationships between Sodexo Supervisors and Ward Managers / Matrons had lost consistency, with wards not having a key contact to work with, this resulted in frustration from ward teams and a sense that issues were not being resolved. All wards have been provided with new contact details, regular walk rounds re-established with Sodexo Supervisor, IPC and ward / senior nurse representation. Membership representation of Sodexo and Estates and Facilities colleagues at RMCH MCS IPC Committee has been refreshed to encourage consistency in regular attendance.

Compliance with IPC Clinical Practice

Hand Hygiene- Focused work with nursing teams has occurred to encourage junior and senior staff to challenge when gaps in hand hygiene are observed, particularly in medics and others this has been further encouraged through roll out of the Gloves Off Campaign, which has provided an opportunity to improve hand hygiene awareness.
Personal protective equipment (PPE)-Whilst PPE audit results are good, observational sense is that professional challenge continues to be required in both mask wearing for staff, correct PPE in care of patients with CPE and education on doffing. This education has been provided as gaps in practice have been observed on SHINE and IPC walk rounds.

Ultraviolet, (UV)/Fogging Decontamination

Prior to April 2022, RMCH at ORC had an Ultraviolet Decontamination System – (Surfacide), a decision was made after 2021/2022-year end review and discussion to cease use of the system due to ongoing maintenance challenges and repeated user error incidents with limited evidence of impact. Since then, Sodexo have gained a contract to provide both ultraviolet and fogging decontamination. Regular schedules of UV decontamination have been agreed for two high risk areas; Ward 86 and Paediatric Critical Care, (PCC). In addition, regular fogging has been planned for BMTU/SCU and Ward 86 particularly as patients are discharged following a prolonged length of stay.
Year end results suggest there has been no negative impact of ceasing the regular use of surfacide in all clinical areas.

Anti-microbial Stewardship

Audit results have not been available from HIVE currently, it is hoped that once this is corrected there will be more detail data in terms of the length of antibiotic courses and other relevant information.
Key messages are emphasised with the medics at induction relating to the expiry of antibiotics.

Anti-microbial Skin Care for patients with CVC

CVC Guidelines for their management in children, recommends an anti-microbial skin care regime for inpatients. Whilst there is good compliance of this in PCC, implementation and compliance in ward areas has been dependent upon speciality engagement, which has been identified through IPC KPI presentations.
The hospital Paediatric Line Specialist Nurse has been working across all clinical areas monitoring performance and providing education and awareness training to nursing and medical teams on the

guidance requirement. Clinical areas are now completing a self audit of their performance which is reported to the Infection Control Committee with action plans.

Hospital/MCS: Wythenshawe, Trafford, Withington, and Altrincham (WTWA)
Date: April 2023

Summary:

Framework for IPC

- **Director of Nursing (DoN); Clinical Lead, Divisional and Corporate Heads of Nursing, Lead Nurses, Deputy Medical Director, IPC Matron and Lead Nurse, IPC doctor, Estates and Facilities Matron.**
- **Record of attendance at all meetings**

- **WTWA Infection Prevention and Control committee (ICC) meeting-** ICC meetings held quarterly and are chaired by the DoN with a focus on risk and assurance. Divisional exception/assurance reports provided to the committee. The ICC reports to the Hospital Management Board and Group Infection Control Committee (GICC) on a quarterly basis.
- **Outbreak meetings**- A thrice weekly outbreak management meeting led by the DoN/DDoN and attended by the clinical teams, IPC representative, Estates and Facilities and Sodexo representatives. The focus of the meeting is to ensure robust management of outbreak.
- **Further IPC governance meetings include;**
  Healthcare associated infection (HCAI) accountability meetings
  Divisional IPC meetings
  WTWA IPC delivery group
  Weekly IPC walkrounds
  Quality and Safety Walkrounds
  Quarterly IPC campaigns
  Monthly Senior Nurse night walkrounds

Healthcare Associated Infections

Healthcare associated infections are reviewed by the clinical Lead Nurses and Matrons. Findings and lessons learnt are shared at local IPC meetings and summarised at the WTWA IPC meeting. The following are some of the issues identified throughout the root cause analysis (RCA) process

- MRSA bacteremia- there has been a slight increase in the number of MRSA bacteremia in comparison to the previous year. Further processes have been implemented to strengthen the accountability for each individual, team, directorate, and division on their practice to ensure compliance with guidelines and policies which includes monitoring MRSA screening compliance. Staff education in the completion of MRSA care pathways via the HIVE electronic patient record system and documentation reviews in cannula insertion and management.
- *Clostridioides difficile* infection (CDI) - there has been a reduction in attributable CDI cases during 2022/23 in comparison to the previous year. Root cause analysis of each case has highlighted the following themes and generation of an action plan to include; Improved Antimicrobial stewardship, prompt isolation of infected patients, contemporaneous documentation of the care pathways, improved hand hygiene compliance and ensuring compliance with cleaning standards.
- Carbapenemase producing Enterobacteriaceae (CPE)- There has been a reduction in the number of CPE acquisitions in comparison to the previous year. Thematic analysis of all cases highlights the following themes, compliance with CPE screening, ensuring ward kitchen cleaning standards are maintained, ongoing audit of hand hygiene and commode cleanliness.

Respiratory Viruses

COVID-19

During 2022/23 WTWA reported 410 hospital onset cases (occurring on or >8 days after admission)

- There were 71 COVID-19 outbreaks throughout the year (where 2 or more cases occurring on or >8 days after admission are identified within a 14-day period)

Influenza

During 2022/23 there were 2 outbreaks of Influenza A affecting 5 patients and 4 staff members.

Outbreaks of Infection

Learning from respiratory virus outbreaks is achieved at thrice weekly outbreak meetings and includes;

- Poor screening compliance
- Inconsistent compliance with hand hygiene
- Inconsistent cleaning standards also linked with poor fabric of the ward
- Inconsistent compliance with personal protective equipment (PPE)
- High volume of visitors with variable compliance to PPE standards

Compliance with IPC Clinical Practice

Hand Hygiene/PPE compliance- observational audits continue to monitor the standards of IPC compliance on wards and departments. Frequency of audit is increased and multi-disciplinary team (MDT) audit of areas out of hours if compliance is low. Focus of glove use reduction across WTWA and ensuring staff remain updated on mask wearing guidance.
There has been a particular focus on engaging with medical staff to improve hand hygiene compliance which includes 'IPC champion role' incorporated into the job description of the Quality and Safety Clinical Director for each division. The escalation of any concerns to the Clinical Head of Division and empowering all staff to challenge colleagues in any noncompliance.

ANTT compliance- ANTT audit compliance between 85-97%, the following actions are implemented if an area falls below 95%; focused training from practice-based educators, oversight on ward managers 1:1 meeting and compliance reported to IPC delivery group and WTWA ICC.

FFP3 Fit testing- Mean fit testing compliance is currently 76.4% with divisions ranging from 52%-94%. The following processes are in place to ensure staff are fit tested.

- 5 days per week (Mon-Friday) fit testing available across Wythenshawe and Trafford Hospitals.
- Uploading of information onto learning hub to ensure this is uploaded on the ESR database
- Monthly education newsletter detailing fit testing requirement and testing sessions sent out to all clinical areas.
- Plan for FIT testing delivery for the future under review WTWA are currently scoping number of WTWA fit testers by Division.

WTWA Priorities for 2023/24

Assurance:

- Back to basics approach
- Quarterly IPC campaign with a focussed theme for each Quarter.
    - Quarter 1-Hand Hygiene and PPE
    - Quarter 2- ANTT (in line with new doctors' induction)

    - Quarter 3- Environment
    - Quarter 4-IPC Pathways
- Divisional IPC meetings to commence from April 2023 to monitor audit compliance and share learning.
- Launch Divisional 'IPC Audit Day' 15th of the month to improve IPC Trust audit compliance. Launch Matrons Peer Hand Hygiene audits from April 2023. Compliance will be monitored via WTWA IPC Committee.
- Continue to monitor IPC Practice compliance by Patient Safety and Quality walk rounds.
- Continue senior nurse night walk rounds and share feedback/learning.
- Continue to embed learning from Covid-19 outbreaks and reduce HOCI.
- Recruit Divisional Quality and Safety clinical leads. Role to incorporate a focus on the IPC agenda and promoting best practice.
- Monitor improvements against IPC practice, lessons learnt and GNBSI action plans via IPC Delivery Group.
- Set IPC divisional stretch targets against AoF (Assurance oversight framework) IPC thresholds.
- Revise IPC HCAI tracker to ensure cases are presented at the accountability meetings in a timely manner to promote early shared learning. DDoN leading current recovery plan to address backlog.
- Transition from monthly action audits of 5 patients per area to hospital-wide antimicrobial point-prevalence surveys of all inpatients 3 times a year using the MEG platform. Oversight via senior nurse meeting and WTWA IPC Committee.
- AMS performance data generated by the point-prevalence survey using the MEG platform will be shared with Divisional Q&S leads. WTWA IPC clinical lead to oversee dissemination and implementation of improvement actions.

Clinical Practice:

- Continue to work towards zero MRSA and VRE bacteraemia's by having robust IPC practices.
- Deliver sustained improvement via the IPC Delivery Group.
- Reduce CPE acquisitions.
- Focus on practice and documentation of indwelling devices.
- Improve and maintain IPC screening standards and embed Divisional assurance processes utilising HIVE.
- Increase medical engagement with regular IPC updates delivered by WTWA IPC clinical lead at Medical Leaders Forum and appointment to Divisional Quality and Safety lead roles.
- Regular senior nurse engagement sessions delivered by the IPC team.
- Departments to carry out risk assessments based on new guidance and usage of face mask and FFP3.
- Improved cross Divisional and Managed Clinical Service working to ensure key stakeholders are engaged in RCA's and accountability processes.
- Launch of Matrons Peer hand hygiene divisional audits from April 2023.

Environment:

- Wythenshawe F block life cycling in progress with plans to lifecycle F15, F16 and F4 during 2023/24.
- Matron SHINE walk around to identify environmental issues and escalate appropriately in line with the National Standard of Cleanliness.
- Continue IPC weekly walk round with the support from corporate HoN and Sodexo.
- ED and F4 identified to be trial wards to receive education and training from Clinell company.
- Carry out ward risk assessments using hierarchy of control to identify high and low risk area.

Hive:

- Embed use of IPC dashboard to review Divisional HCAI's at daily senior nurse huddle.
- Embed use of the IPC dashboard to review the completion of IPC pathways at daily huddle.
- Carry out twice yearly audits to review compliance with IPC pathways and to drive improvement – Q1 / Q3.

Risk:

- Identify WTWA risks to the delivery of IPC agenda and carry out risk assessment with robust mitigations in place. Review to be completed during Q1.
- IPC database to be used to reduce the back log of RCA's and ensuring robust monitoring.

Conclusion

During 1st April 2022- 31st March 2023, WTWA have continued to adapt their practices in line with current Covid-19 guidance, policies, and learnings to reduce HCAI's. WTWA are committed to provide the best patient care and have a robust governance and accountability oversight framework in place to ensure the delivery of such.

Hospital/MCS: Manchester Royal Eye and University Dental Hospital Manchester MRE/UDHM

Date: April 2023

Summary:

Framework for IPC

- **Director of Nursing (DoN); Medica Director, Divisional and Corporate Heads of Nursing, Lead Nurses, Deputy Medical Director, IPC Matron and Lead Nurse, IPC doctor, Estates and Facilities Matron.**
- **Record of attendance at all meetings**

MRE/UDHM Infection Prevention and Control committee (ICC) meeting- The MREH/ UDHM hold a joint monthly Infection, Prevention, Control Committee meeting, which is chaired alternately by either the Director of Nursing or one of lead clinicians from the MREH or UDHM.

The joint Hospital Infection, Prevention, Control Committee meetings report into the Hospitals' Quality and Safety Committee and ultimately the Hospital Management Boards for oversight, accountability and assurance purposes. The Committee also provides quarterly reports to the MFT Group Infection Control Committee.

The Hospitals' Infection, Prevention and Control Committee is attended by the multi-disciplinary team from both hospitals in addition to the Medical Director for each Hospital and the Director of Nursing.

The incidence and lessons learnt from HCAIS, training and audit compliance is presented and discussed at every Hospital Infection, Prevention and Control Committee meeting for assurance purposes, in addition to learning from incidents, risks and HLI's. Other items included on the agenda specific to the pandemic include National and local COVID-19 updates, vaccination, fit testing, and specifically communication of changes to policy and guidelines. Changes to guidance over the last year have resulted in some respects being withdrawn such as Lateral Flow Testing (LFT) and Hands/Face/Space audits.

Healthcare Associated Infections

Healthcare associated infections are reviewed, MRE monitor rates of endophthalmitis and UDHM monitor rates for acute apical abscess requiring intravenous antibiotics, with each identified case being subject to a rapid learning review.

- Apical abscesses -there were none reported in 2022/23
- Endophthalmitis- there were 7 cases reported in 2022/23, with 5 cases being inflammatory causes (not infective) and 2 cases being infective.
- In comparison to 2021-2022, this represents a reduction in endophthalmitis cases from 17 reported, with 1 of these cases having an infected bacteria isolated and 6 cases which were identified as having an inflammatory cause not attributable to the MREH
    - Prevalence of endophthalmitis cases in MREH 2022-2023 reported average of 0.014%. National average for endophthalmitis cases is between 0.02% and 0.71%.

Respiratory Viruses

COVID-19

During Apr 2022-March 2023 MRE reported 5 community onset cases
There were 0 COVID-19 outbreaks throughout this time period

Influenza
During 2022/23 there were 0 outbreaks of Influenza A

Outbreaks of Infection

There were no outbreaks of infection within MRE/UDHM however significant work was undertaken and remains ongoing across both MRE/UDHM in response to the COVID-19 pandemic including

- Patient pathways and management processes revised in line with changes to National and Trust guidance to ensure compliance.
- SOPs updated to define and describe patient management and pathways.
- Patient management in clinical areas reconsidered and zoned as respiratory and non-respiratory pathways change September 2022.
- Reconfiguration of some services needed due to the age and fabric of the estate and the lack of ventilation continues. This includes the use of air filtration systems.

Compliance with IPC Clinical Practice

Hand Hygiene/PPE compliance- The MRE/UDHM audit results demonstrate a high level of compliance with any non-compliance being individually addressed contemporaneously.

- UDHM HH compliance overall 2022/23 100%
- MRE HH compliance overall 2022/23 99.7%

- UDHM PPE compliance 100%
- MRE PPE compliance 99%

UDHM ANTT compliance-

- Clinician 72.38%
- Nursing 95.74%

High number of Dental tutors work minimal sessions within the Dental Hospital. Therefore, there is a challenge in accessing training. A rolling training programme in place for these staff. ANTT Roadshows scheduled at ACE days to target medical staff and Associate Medical Directors discussing 1:1 with all medical colleagues

MRE ANTT compliance-

- Medical staff 52.4%
- Nursing staff 91.49%
- Optometrist/Orthoptist/Imaging 90.96%

Monthly review to validate and update centrally held records on Learning Hub. Locally held records maintained for assurance. There is a requirement for medical compliance focus
ANTT Roadshows scheduled at ACE days to target all staff. ANTT drop-in sessions organised. Associate Medical Directors discussing 1:1 with all medical colleagues

FFP3 Fit testing-
UDHM compliance- The fit testing programme undertaken at UDHM has successfully resulted in 73% of nursing fit test trained and 91% of clinicians fit test trained
MRE compliance- The fit testing programme undertaken at MRE has successfully resulted in 74.8% of nursing fit test trained, 15.3% of clinicians fit test trained and 42.24% of allied health professionals fit test trained.

Risk register

All infection related incidents and risks are discussed at the joint IPC Committee monthly.

There are currently 4 risks on the MRE Risk Register related to IPC including,

- Reduction in the standards of cleaning across the OPD modules and MRE atrium
- Decontamination of ophthalmic lenses and the risk of cross infection – SOP in place to manage
- FFP3 fit testing for MRE staff to include all clinical areas.
- Water testing at the macular treatment centres (MTC) at North and South differs from the water testing on the ORC and Trafford carried out by MFT estates. There is concern as to whether the water testing carried out off site complies with MFT water testing requirements

There are currently 7 risks on the UDHM Risk Register related to IPC including,

- A reduction in the standard of cleaning
- Fabric of the building- poor standards of ventilation in the UDHM hospital
- FFP3 fit testing for UDHM staff to include all clinical areas
- Non-compliance with manufacturer's instructions by DSD
- Water outlets to older dental chairs carries an infection risk
- Ground floor museum cabinets and first floor museum/storage area requires a programme of decluttering and cleaning
- Mix of aerosol generating procedures (AGP) on open plan clinics

Hospital/MCS: Manchester Royal Infirmary
Date: April 2023

Summary:

Framework for IPC

- **Director of Nursing (DoN); Clinical Lead, Divisional and Corporate Heads of Nursing, Lead Nurses, Deputy Medical Director, IPC Matron and Lead Nurse, IPC doctor, Estates and Facilities Matron.**
- **Record of attendance at all meetings**

- **MRI Infection Prevention and Control committee (ICC) meeting-** ICC meetings held monthly and are chaired by the DoN with a focus on risk and assurance. Clinical services unit (CSU) exception/assurance reports provided to the committee. The ICC reports to the Hospital Management Board and Group Infection Control Committee (GICC) on a quarterly basis and the Risk committee.
- **Outbreak meetings**- A thrice weekly outbreak management meeting led by the DoN/DDoN and attended by the clinical teams, IPC representative, Estates and Facilities and Sodexo representatives. The focus of the meeting is to ensure robust management of outbreak.
- **Further IPC governance meetings include;**
  MRI Integrated performance review dashboard
  Monthly Integrated performance data-
  Accountability meeting (weekly)
  Presentation of MRSA Bacteraemia
  IPC/COVID Outbreak process
  Weekly IPC walk rounds
- **Other Mechanisms include;**
  Practice audits- HH, PPE and donning and doffing
  QCR and WMTM
  Weekly HCAI surveillance reports
  Standards of cleaning
  Improvement work (IQP)

Healthcare Associated Infections

Healthcare associated infections are reviewed by the clinical Lead Nurses and Matrons. Findings and lessons learnt are shared at local IPC meetings and summarised at the MRI IPC meeting. The following are some of the issues identified throughout the root cause analysis (RCA) process

- MRSA bacteremia- there has been a slight increase in the number of MRSA bacteremia in comparison to the previous year. Root cause analysis of each case has highlighted issues with MRSA screening compliance. There are also gaps in documentation including ANTT documentation and decolonisation therapy documentation. It was identified there were delays in prescribing the decolonisation therapy and delays in being able to isolate MRSA positive patients.

- *Clostridioides difficile* infection (CDI) - there has been an increase in attributable CDI cases during 2022/23 in comparison to the previous year. Root cause analysis of each case has highlighted the following themes and generation of an action plan to include, Improvement in cleaning standards both environment and patient shared equipment. Increased compliance with good antimicrobial stewardship and avoiding delays in obtaining stool samples.
- Carbapenemase producing Enterobacteriaceae (CPE)- There has been a 61% increase in the number of CPE acquisitions in comparison to the previous year, predominantly driven by a sustained outbreak on the Manchester Vascular Centre (MVC) Thematic analysis of all

cases highlights the following; compliance with CPE screening, ensuring ward kitchen cleaning standards are maintained, ongoing audit of hand hygiene and commode cleanliness, isolation capacity and completion of care pathways.

Respiratory Viruses

COVID-19

During Apr 2022-Feb 2023 MRI reported 509 hospital onset cases (occurring on or >8 days after admission)

- There were 52 COVID-19 outbreaks throughout this time period (where 2 or more cases occurring on or >8 days after admission are identified within a 14-day period)

Influenza

During 2022/23 there were 9 outbreaks of Influenza A affecting 58 patients and 11 staff members in total.

Outbreaks of Infection

Learning from respiratory virus outbreaks is achieved at thrice weekly outbreak meetings and includes;

- Challenges with isolation capacity as this is limited within the hospital
- Large bays increased the risk of cross transmission between patients
- Inconsistent cleaning standards
- Patient moves within base wards increased the risk of transmission of covid between groups of patients.

Compliance with IPC Clinical Practice

Hand Hygiene/PPE compliance- The Hand Hygiene audit shows that on average **97%** of Nursing staff were compliant with hand hygiene and PPE. It also shows that **86%** of medical staff and **95%** of Allied Health Professionals (AHP) were compliant. The PPE audit highlighted that masks were not always worn as per guidance, that staff did not always wear the correct PPE when delivering patient care and staff did not always wear gloves appropriately. The following processes were implemented to improve compliance.

- Glow box and education targeted in areas with poor compliance of HH audits which included specific ward-based campaigns in Vascular, Haematology and ward 7
- Actions updated in CSU IPC assurance report and updated at monthly IPC committee
- Education provision on the appropriate use of gloves. The 'Gloves Off' campaign continues into 2023/24 with MRI achieving inappropriate glove use reduction during Q3 and Q4 last year
- The MFT Deputy Directors of Nursing are working on a MFT wide improvement project focussing on HH/PPE audit, compliance and observation.

ANTT compliance- The ANTT Assessor Programme continues to be delivered by the MRI Education Team. **146** Assessors have been trained across the MRI in accordance with the new peer reviewed (evidence-based standards) which was developed by the MRI Education Team. ANTT April 2023 launched to increase assessor numbers across the MRI and provide assurance. Local hand hygiene champions in each CSU, focus on hand hygiene and ANTT in April 2023.

FFP3 Fit testing- National support for FFP3 fit testing provision by Ashfield Healthcare was withdrawn in March 2023. The MRI Education team will continue to offer weekly fit testing clinics for MRI staff only. Discussions are being held at a group level to formulate next steps to meet the demands for fit testing across MFT. From October 2022 to date, **229** staff have been Fit Tested on the new disposable FFP3 masks as per national guidance.

MRI Priorities for 2023/24

Education & Training

ANTT APRIL

- Team education session throughout the month of April on ANTT
- ANTT assessor masterclasses to increase the number of ANTT assessors across MRI for medical and nursing staff

Interactive roadshow across all departments using light box technology, quizzes, and promotional material.
MRI trust induction all staff are ANTT, and Hand hygiene assessed.
Peer Hand Hygiene audits and feedback
Gloves off campaign – MRI Delivered reduction in gloves usage and looking to further reduce usage during 2023/24
Audit and Clinical Effectiveness (ACE) day including education, training and assessment planned for May 2023
HIVE Training to include integrated care pathways

Education & Training/ Improvement work

MRI IPC Improvement collaborative

The collaborative commenced December 2023 using MRI Improvement Methodology to look at IPC challenges differently
2 out 3 collaborative workshops delivered with CSU teams with each CSU clinical area committing to deliver one improvement project each.
A third session is planned for May 2023 to review the impact of improvement work implemented to date.

Surveillance & Monitoring (screening and alerts)

Heads of Nursing established daily/weekly processes to monitor screening compliance whilst HIVE dashboard data is awaited
Achieving Excellence in IPC Fundamentals is a monthly programme of education
Review of matron portfolio/focus completed
Observations in practice – suite of tools and processes now available

Antibiotic Stewardship

Clinical Directors are working with Heads of Nursing with a specific focus on antimicrobial stewardship whilst using HIVE data to inform improvement

Cleaning & Environment (National Cleaning Standards)

A new bone marrow transplant unit was opened during 2022/23 to increase isolation facilities and improve the patient environment and the patient experience. MRI life cycling of ward 7 and ward 8 is due to commence Q1 of 2023/24. There is also the commissioning of a new ward (ward 10) to increase bed capacity and reduce occupancy. The 'Home First' Delivery Programme to reduce length of stay and contribute to occupancy reduction.

MRI IPC Delivery group including making MRI shine - Chaired by DDON reporting into MRI ICC
MRI Cleaning Improvement Delivery Group – Chaired by Director of Nursing with E&F representatives.

Conclusion

During 1st April 2022- 31st March 2023, MRI have continued to adapt their practices in line with current Covid-19 guidance, policies, and learnings to reduce HCAI's. MRI are committed to provide the best patient care and have a robust governance and accountability oversight framework in place to ensure the delivery of such.

Hospital/MCS: Saint Mary's Managed Clinical Service (SMH/MCS)
Date: April 2023

Summary:

Framework for IPC

- **Director of Nursing & Midwifery (DoM); Clinical Lead, Divisional and Corporate Heads of Nursing, Lead Nurses, Assistant Director of Quality and Safety, IPC Nurse, IPC Doctor.**
- **Record of attendance at all meetings**
- **SMH MCS Infection Prevention and Control committee (ICC) meeting-** Due to the cohort of patients who access care across the MCS, it is possible to combine Infection Control and Harm Free Care into one meeting. ICC meetings are held monthly and feed into Saint Mary's MCS Quality and Safety Committee. (SM MCS Q&S)
- **Outbreak meetings**- Outbreak Control Teams are convened as required and chaired by the Senior Leadership Team with representation from clinical teams, IPC nursing and medical team, Estates and Facilities and Sodexo. The focus of the meeting is to ensure robust outbreak management

Healthcare Associated Infections

Healthcare associated infections are reviewed by the clinical Lead Nurses and Matrons. Findings and lessons learnt are shared at local IPC meetings and summarised at the SMH MCS ICC meeting.

Gram negative bacteraemia: From April 2022 to February 2023 there were 11 Gram Negative bacteraemia cases within across SM MCS.

- Within Newborn Services there were 9 cases (11 reported in 2021/22) 7 cases were considered unavoidable with 2 cases currently being reviewed. The themes identified were intra venous long line/ dressing documentation. To address this, an increased awareness of the importance of timely escalation of dressing score changes, in line with guidance has been provided to all staff members. Following the induction of Hive, auditing the long line care bundle required addition build which completed in March 2023. The new audit (inclusive of the safety checklist) commenced at the end of March 2023.
- Within Maternity Services there were 2 cases both cases were considered unavoidable with no common themes. Root cause analysis considered that one case was a result of a contaminant

***Clostridioides difficile* Infection (CDI):** From April 2022 to March 2023 there were 0 reported CDI cases (3 reported in 2021/22)

MRSA acquisition: From April 2022 to March 2033 there were 12 reported cases of MRSA acquisition (reduction from 18 cases in 2021/22) 11 reported in Newborn Services –IPC improvement plans were implemented including

- Review of blood culture sampling within the unit
- Aseptic non touch technique (ANTT) compliance review
- Weekly SHINE walkround undertaken by Matrons as assurance of IPC standards
- Weekly hand hygiene and PPE audits
- IPC action plan reviewed with actions added from walk rounds.

Respiratory Viruses

- COVID-19: from April 2022 to March 2023 there were 4 reported cases of healthcare associated COVID-19 infection. All cases were investigated, and appropriate action plans implemented.

Outbreaks of Infection

- During 2022/23 there were 2 *Klebsiella Pneumoniae* Extended Spectrum Beta Lactamase (ESBL) outbreaks within the Newborn Services unit.
- During 2022/23 there was *1 Burkholderia cenocepacia* and *Stenotrophomonas maltophiilia* outbreak which occurred within the Newborn Services unit.
- Outbreak Control teams consisting of Senior leadership colleagues, Clinical team representatives, IPC nursing and medical teams managed each outbreak supported by both national and local UKHSA colleagues.

Compliance with IPC Clinical Practice

- Hand hygiene, PPE and ANTT audits continue to be undertaken monthly with compliance above 90% in most groups throughout 2022/23.
- Audits for each division are reported to SM MCS Infection Control and Harm Free Care meeting. Action plans are put in place for any area falling below 90% and progress is monitored.

Hospital/MCS: Manchester & Trafford Local Care Organisation (MLCO)
Date: March 2023

Summary:

Framework for IPC

- **Director of Nursing & Professional Lead (DoN), Clinical Lead, Heads of Nursing, Lead Nurses, IPC Nurse and IPC Doctor**
- **Record of attendance at all meetings**
- **MLCO Infection Prevention and Control committee (ICC) meeting-** occurs quarterly and these are chaired by the Director of Nursing & Professional Lead and attended by senior clinical professionals from both the LCO and the Manchester Foundation Trust (MFT) IPC team

Healthcare Associated Infections

Healthcare associated infections are reviewed. Findings and lessons learnt are shared at local IPC meetings and summarised at the MLCO ICC meeting.

MRSA- There were two incidents of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia investigated by M&TLCO from 1st April 2022 – 14th March 2023. None of these were attributable to the LCOs. There were two MRSA colonisation acquisitions during the same period - one at Dermot Murphy and one at Buccleuch Lodge.

Clostridioides difficile- There have been no incidents in community in-patient facilities from 1st April 2022 to 14th March 2023 (compared to 1 incident during 2021/22). There have been no incidents of Carbapenemase producing Enterobacteriaceae (CPE), Vancomycin-resistant Enterococcus (VRE) or Gram-negative bacteraemia (GNBSI) during the same period.

Respiratory Viruses and Outbreaks of Infection

COVID-19- Between 1st April 2022 and 14th March 2023 there have been 7 outbreaks of COVID-19 in community inpatient facilities affecting 26 patients and 14 staff. Of the outbreaks affecting patients, 92% were hospital onset COVID infections (HOCI), i.e. patients who tested positive on or after day 8 of admission to the Trust.

Influenza- There has been one Influenza outbreak during the same period and one Norovirus outbreak. The Norovirus outbreak affected 11 patients and one member of staff with all positive results relating to the same physical area (corridor) of Delamere Intermediate Care Unit at Gorton Parks.

Outbreaks- There were no themes identified during the COVID outbreaks although several recommendations were enacted following outbreak meetings. The Norovirus outbreak identified three issues (lack of faecal samples obtained, incorrect cleaning products utilised and lack of consistent domestic support due to sickness absence). An action plan was implemented to support improvement.

Compliance with IPC Clinical Practice

At the end of December 2022 compliance with IPC mandatory training for Level 1 was 96% and 87% for Level 2.
Hand hygiene and PPE audits are undertaken monthly. Compliance with Hand Hygiene was 99% and PPE is available and stored for staff to access.

Hand Hygiene audits and ANTT are reported at the M&TLCO Infection Prevention and Control meeting. ANTT eLearning compliance at the end of December 2022 was 77% however

Practical ANTT training was 60%. This was reported to be largely due to changes in reporting and is anticipated to rise as recording compliance improves.

A team were deployed during covid to carry out FIT testing centrally 1 day per week. Guidance is for all staff to continue to be fit tested every 2 years for resuscitation and protection of airborne viruses. Staff undertaking AGPs are prioritised for training and a plan has been developed for 23/24 however current compliance is 34% across the LCOs.

There are several ongoing IPC challenges which the LCO have identified including ongoing fit testing capacity, discharge swabbing from hospital facilities, the classification of community bedded facilities and reporting systems.

M&TLCO IPC priorities for 2023/2024

- Member of IPC medical team attendance at LCO IPC meetings to strengthen IPC offer and reflect consistency across MFT.
- North Manchester community services to receive IPC advice and support from the LCO deployed community IPC/TV team
- Consideration of IPC support for bed bases
- Development of dashboards within HIVE
- To be responsive to IPC environmental audits and develop action plans to address issues raised
- To improve mandatory training compliance to consistently achieve above 95%
- To move from central fit testing team to locality based fit testing.

Agenda Item 11.2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Ruth Speight, Assistant Chief Nurse Alison Lynch, Group Deputy Chief Nurse
Date of paper:	July 2023
Subject:	Safeguarding Children, Adults, and Vulnerable Groups Annual Report 2022-2023
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support • Accept ✓ • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	To focus relentlessly on improving access, safety, clinical quality and outcomes To improve continuously the experience of patients, carers and their families
Recommendations:	The Board of Directors are asked to: - Note the information relating to adults and childrens safeguarding, looked after children, mental health, and child & adolescent mental health services provided within this annual report; and, - Accept the recommendations within each chapter
Contact:	Name: Alison Lynch, Group Deputy Chief Nurse Tel: 0161 276 8862

Safeguarding

Children, Adults, Vulnerable Groups

Including:

Looked After Children

Annual Report, and

Mental Health Reports

2022-2023

Authors:

Ruth Speight, Assistant Chief Nurse, Safeguarding

Alison Lynch, Group Deputy Chief Nurse

In collaboration with the MFT Safeguarding Teams

1. Purpose of the Report

1.1. The Safeguarding Annual Report for 2022-2023 provides assurance to the Board of Directors that Manchester University NHS Foundation Trust (MFT) is fulfilling its statutory safeguarding responsibilities as outlined in Section 11 of the Children Act 2004[1] and in the Care Act 2014[2] and regulatory standards[3]. This report provides assurance that systems are in place to support MFT staff to keep service users safe and protect them from neglect or harm whilst they are in the care of MFT Hospitals, Managed Clinical Services (MCS) or Manchester and Trafford Local Care Organisations (MLCO, TLCO). The report also identifies how patients, service users and their loved ones have a voice, by ensuring that they are actively involved in decision-making regarding their safety and protection, ensuring that they feel safe.

1.2. The report also informs the Board of Directors of the internal and external safeguarding activity undertaken in 2022-2023 and outlines the key priority areas for 2023-2024.

1.3. Safeguarding activity is underpinned by statutory and regulatory guidance outlined in **Figure 1**. This is not an exhaustive list but outlines the key legislation, statutory and policy guidance that the Trust is required to follow to ensure statutory safeguarding compliance.

1.4. Key Documents

Figure 1: Standard and Statutory Guidance

- CQC registration standards, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13
- The Children Act (1989)
- The Children Act (2004)
- Domestic Abuse Act (2021)
- Female Genital Mutilation Act
- Health and Care Act 2022
- The Sexual Offences Act (2003)
- The Serious Crime Act (2015)
- The Care Act (2014)
- Mental Capacity Act (2005)
- Mental Capacity Amendment Act (2019)
- Mental Health Act (2007)
- Prevent Duty 2015
- Serious Violence Duty 2022
- Working Together to Safeguard Children (2018)
- Adult Safeguarding: Roles and Competencies for Health Care Staff (2018)
- Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)

[1] The Children Act 2004
[2] The Care Act 2014
[3] CQC registration standards, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 13

SECTION B

Executive Summary

2. Executive Summary

2.1 This 2022-2023 annual report reflects the depth and breadth of activity undertaken and the progress made throughout the Trust in relation to safeguarding, Looked after Children health services and safeguarding vulnerable groups including people with mental health difficulties, learning disability and/or autism.

2.2 The MFT Safeguarding and Looked after Children Teams work with other health organisations and multi-agency partners to ensure a cohesive and consistent approach to safeguarding the unborn, children, young people and adults at risk across the MFT footprint.

2.3 Safeguarding and Looked after Children services continue to operate at a whole system level across the Trust, Manchester, Trafford and beyond. Throughout the year, the underpinning principle has remained unchanged: ***'We listen, we believe, we act'.***

2.4 Supporting staff to ensure that all patients and service users are protected is crucial to ensuring safe and effective safeguarding of all age groups regardless of ethnicity, religion, gender, or background. Central to this message is listening and hearing the voice of children, young people, adults at risk and their families and ensuring that safeguarding is always made personal. Hearing the voice of patients and service users is vitally important to the Trust.

2.5 The safeguarding, Looked after Children, mental health and learning disability specialist service is delivered as a single corporate, Trust-wide service, with teams based at two community and four hospital sites. The service provides a resilient, visible, and accessible offer across all our hospitals/MCS/local care organisations (LCO).

2.6 Safeguarding Training is an area of focus for 2022 – 2023. The year-end data identifies expected compliance levels are achieved in level 1 training, however further work is required to improve level 2 and 3 adult and child safeguarding training in order to achieve the Trust's target compliance level of 90%, and will be a targeted focus area for monitoring by the Group Safeguarding Committee.

2.7 The level 3 adult safeguarding training has shown an increase in the number of staff completing the training but, the trajectory to achieve 90% was not achieved with only 70% of mapped staff (**8,345** out of **11,962**) achieving the training. Level 3 child safeguarding training compliance remains at **72%** (**5,692** out of **7,935** of the mapped staff) achieving the training; as described in section 2.6 above, the Group Safeguarding Committee will oversee targeted improvements during 2023 – 2024.

2.8 MFT Child and Adolescent Mental Health Service (CAMHS) are specialist NHS mental health services for children and young people covering Manchester Salford and Trafford. We offer assessment, diagnosis, treatment and support for young people who are experiencing problems with their emotions, behaviour or mental health across a range of conditions and specialisms.

2.9 MFT CAMHS have grown as a Clinical Service Unit/directorate reporting into the leadership team at the Royal Manchester Childrens Hospital (RMCH) (RMCH) expanding its locality footprint and its provision from 22 to 44 services. The CSU was awarded 'Outstanding' by CQC in 2016 and 2019.

2.10 CAMHS CSU is expected to continue to grow throughout 2023/24 and support the delivery of large-scale transformation programme that seeks to modernisation (applying digital technologies) and implement new care models(THRIVE) and improve patient flow (demand and capacity) modelling.

2.11 Throughout this year, the safeguarding, Looked after Children service and CAMHS has continued to review models of working to further 'future-proof' safeguarding in MFT. The safeguarding teams have continued to develop a consistent and unified approach across the Trust with the implementation of the Hive electronic patient record supporting this approach.

2.12 Key drivers that have shaped the safeguarding and Looked after Children services during 2022-2023.

Figure 2 provides an overview of some of the national drivers that have informed the Trust's safeguarding priorities.

Figure 2: Key Drivers

Key Driver	Key Change
Mental Capacity Amendment Act (2019)	Preparation for implementation of the Liberty Protection Safeguards (LPS) to replace the Deprivation of Liberty Safeguards has been completed. The Trust contributed to the national consultation on the code of practice. Now LPS is on hold there will be a refocus on promoting legal literacy and application of the Mental Capacity Act across the workforce.
Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework revised 2022.	The guidance sets out the safeguarding roles and responsibilities of health providers in NHS funded care including the implementation of Child Protection Information Sharing System. This framework informs the Integrated Care Board Greater Manchester Contractual Standards which have been completed by MFT this year.
Adult Safeguarding: Roles and Competencies for Health Care Staff (2018) Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff (2019)	The MFT mandatory safeguarding training programme has been revised to incorporate a "Think Family" approach based on the requirements of the Intercollegiate documents.
NHS Long Term plan[4] - CAMHS	The NHS Long term Plan (LTP) requires by 2023/24 that 345,000 additional CYP aged 0-25 will have access to support via NHS-funded mental health services and school- or college-based Mental Health Support Teams (in addition to the FYFVMH commitment to have 70,000 additional CYP accessing NHS services by 2020/21).

[4] https://www.longtermplan.nhs.uk/areas-of-work/mental-health/

	There will be a comprehensive offer for 0-25 year olds in place by end 2024 that reaches across mental health services for CYP and adults. The 95% CYP Eating Disorder referral to treatment time standards achieved in 2020/21 will be maintained. There will be 100% coverage of 24/7 mental health crisis care provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions • CYP mental health plans will align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice

2.13 The MFT Care Quality Commission (CQC) Inspection report, published in March 2019, recognised that effective systems were in place to safeguard patients in the organisation, citing several examples of good practice. However, the inspection report also highlighted that the Trust should review its systems to provide assurance that the required staff have completed their mandatory safeguarding training. This was a key priority for the safeguarding service working with the Hospitals, MCS and LCOs in 2022-2023. A revised "Think Family" training programme has been implemented. The year-end data identifies expected compliance levels are achieved in level 1 training, however further work is required to improve level 2 and 3 adult and child safeguarding training in order to achieve the Trust's target compliance level of 90%, and will be a targeted focus area for monitoring by the Trust Safeguarding Group

2.14 The Trust has actively supported the work of the Manchester Safeguarding Partnership and Trafford Strategic Safeguarding Partnerships (MSP and TSSP). The safeguarding service has worked to ensure representation at the partnership boards, and subgroups. The partnership priorities have informed the Trust's safeguarding work plan, governance group workstreams and audit plan. The revised TSSP priorities launched in February 2023 and MSP priorities expected to be launched in Summer 2023 will inform the development of a MFT Safeguarding Strategy in 2023-24.

2.15 The Hive digital system was implemented across MFT in September 2023. The new system supports professional curiosity in safeguarding and has enabled a robust system to document and report on safeguarding concerns including supporting delivery of personalised care for vulnerable patients. In May 2022 during an IT outage at North Manchester General Hospital (NMGH) safeguarding reporting, information sharing and documentation was maintained through delivery of a business continuity plan.

2.16 Deprivation of Liberty Safeguards (DoLS) remains a challenge both nationally and within the Trust. In 2019 the Mental Capacity (Amendment) Act (MCA) set out proposed changes to legislation, which reforms the process for authorising arrangements for people who lack capacity to consent to their care or treatment.

The new legislation recommends that DoLS are repealed and replaced by a new Liberty Protection Safeguards (LPS) process, which will streamline the process for the deprivation of an individual's liberty where appropriate. In 2019 the new legislation was given royal assent, however, there has been a delay in the national implementation plan with the MCA and LPS Code of Practice consultation being completed in 2022, with no confirmed date for implementation. The current challenges with the DoLS process are associated with limited capacity within the Local Authority (LA) DoLS teams to undertake timely assessments to enable the authorisation of the deprivation of liberty. Across MFT this issue has been acknowledged and processes are in place to recognise and escalate the risk this poses to the Trust for any patient who is deprived of their liberty.

2.17 There has been a notable increase in reporting of adult, children and young people safeguarding concerns this year. Frontline staff are increasingly recognising and responding to indicators of abuse and neglect. Safeguarding reporting related to neglect in the care of adults and children, domestic abuse and the impact of mental health difficulties on safeguarding are the most frequent categories of abuse or neglect reported to the safeguarding team, this is consistent with the national data. The safeguarding response to concerns around neglect and mental health will continue to be a priority for MSP, TSSP and the Trust next year.

2.18 Following investment by the Trust in a new team of specialist mental health and learning disability nurses in 2020, this year the established team has provided specialist leadership and support to frontline services to promote high quality care and reasonable adjustments for our patients with a learning disability and/or autism or mental health difficulties. there has been a review of MFT services provided for people with a mental health problem based on the statutory and regulatory guidance focussing on the voice and experience of people. An MFT Mental Health Strategy has been developed. Provision of hospital care has been benchmarked against regulatory standards for people with a learning disability and autism with training programmes developed to support the workforce in providing high quality individualised care. Further training will be developed in line with mandated requirements of the Health and Care Act 2022[5] in the care of people with learning disabilitiy in 2023-24. The MFT Learning Disability and Autism strategy was launched in June 2022, with task and finish groups established to deliver the strategic priorities.

2.19 In this annual report year the Trust has completed the MSP self-assessment 'Section 11' of the Children Act 2004 audit, the Adult Assurance self-assessment and the Greater Manchester (GM) Safeguarding Contractual Standards 2022-23 audit tool to measure compliance with the NHS Assurance and Accountability Framework for Safeguarding[6]. The outcome of these audits has demonstrated that MFT is compliant with statutory requirements and has an action plan in place to improve safeguarding standards in the application of the Mental Capacity Act, Mental Health Act, promote the least restrictive response to people in distress and improve recognition and response to adults at risk of self-neglect.

[5] The Oliver McGowan Mandatory Training on Learning Disability and Autism
[6] Safeguarding children, young people and adults at risk in the NHS Safeguarding accountability and assurance framework, revised 2022

2.20 Throughout this year, safeguarding has remained a key priority for the Trust and the safeguarding service has continued to work with frontline staff to respond to changes in legislation, policy and practice, messages from research and reviews in order to prioritise safeguarding the unborn, vulnerable children, young people, adults at risk and their families. Every day on average **95** safeguarding alerts are raised across the Trust.

2.21 In summary, during 2022-2023, the MFT safeguarding service has continued to lead and develop arrangements across the Trust in the context of significantly increasing activity, to meet local and national challenges whilst remaining focussed on ensuring that patients/service users are afforded safety and protection whilst in the care of the Trust, and that staff are supported to listen, recognise, respond and act to ensure the best outcomes for vulnerable people.

SECTION C

National Overview and Reflections on Manchester City-wide and Trafford Safeguarding

3. Manchester and Trafford Overview

3.1 The city of Manchester is a culturally diverse metropolitan borough of Greater Manchester. Manchester is the 6th most deprived borough in the country[7] and consists of 12 local neighbourhoods each with their own unique culture and demography. The index of multiple deprivation identifies that the majority of Manchester neighbourhoods are in the most deprived neighbourhood nationally[8], Trafford is classified as 191st out of 317 in the index of deprivation (1 is the most deprived); it is comprised of 21 local wards[9]. MFT provide acute and community health services across Manchester and Trafford. This requires the safeguarding provision to span the diversity and specific needs of all of these neighbourhoods and wards.

Keeping People Safe in Manchester and Trafford

3.2 The Manchester Safeguarding Partnership vision is[10]:

> "Working together to create a place where all children and adults in Manchester are safe, free from abuse and neglect and supported to live happy and healthy lives.

3.3 The Trafford Safeguarding partnership[11] aim is to:

> "To be assured that the safeguarding partners and all relevant agencies are committed to ensuring that safeguarding arrangements for adults and children are of the highest quality and that they consistently promote effective safeguarding".

3.4 As a committed partner, MFT embraces these visions and has established robust systems to ensure that people at risk who access MFT services are protected from abuse and neglect.

Safeguarding Adults at Risk

3.5 **Safeguarding Adults at Risk National and Local Context**

3.6 The Care Act (2014) outlines the following categories of abuse for adults:

[7] Manchester Indices of Deprivation
[8] Greater Manchester Poverty Action
[9] Trafford Joint Strategic Needs Assessment
[10] Manchester Safeguarding Partnership Annual Report 2021-2022
[11] Trafford Strategic Safeguarding Partnership

Figure 3: Categories of Abuse

3.7 All MFT staff, regardless of their role, have a part to play in identifying and escalating safeguarding concerns, along with taking the necessary steps to prevent harm or abuse occurring. This includes the identification of professional practice, which may put a patient or service user at risk.

3.8 The latest national data for Safeguarding Adults in England 2021-22 identifies key themes (**Figure 4** below).[12]

Figure 4: Key themes identified by National Data for Safeguarding Adults in England (based on the most recent national data)

- There was a 9% increase in safeguarding concerns (to 541,535) on the previous year.
- There was a 6% increase (to 161,925) in section 42 adult safeguarding enquires.
- The most common type of risk in section 42 adult safeguarding enquiries was neglect and acts of omission, which accounted for 31% of risks.
- The most common location of the risk was the person's own home at 48%.
- In 91% of completed section 42 enquiries the outcome was that the risk was reduced or removed.

3.9 The MSP commitment for safeguarding adults is:

'Ensuring every citizen in Manchester is able to live in safety, free from abuse and neglect'.

'Everyone who lives and works in the City has a role to play.'

[12] Safeguarding Adults, England 2021-22

3.10 TSSP[13] identifies adult safeguarding as:

> "Protecting an adults right to live in safety, free from abuse and neglect. It is about people and organisations working together to present and stop the risk and experience of abuse and neglect whilst ensuring the adult's wellbeing is promoted."

3.11 **Figure 5** below explores the number of safeguarding concerns and section 42 adult safeguarding enquiries in England, Manchester and Trafford in the latest available national data set (2021-2022)[14] with a comparison to the previous year.

Figure 5: Safeguarding adult concerns and section 42 adult safeguarding enquiries

Area	Number of safeguarding Adult Concerns			Section 42 Enquiries Adult Safeguarding Enquiries		
	2019/20	2020/21	2021/22	2019/20	2020/21	2021/22
England	475,560	498,260	541,535	161,910	152,270	161,925
Manchester	11,075	13,180	6,6135	945	1,475	680
Trafford	4,525	4,860	7,495	435	415	400

The number of reported safeguarding concerns has increased in England and Trafford, whilst decreasing significantly in Manchester. However, the number of concerns converted to adult safeguarding enquiries has increased in England but has reduced significantly in Manchester and slightly in Trafford.

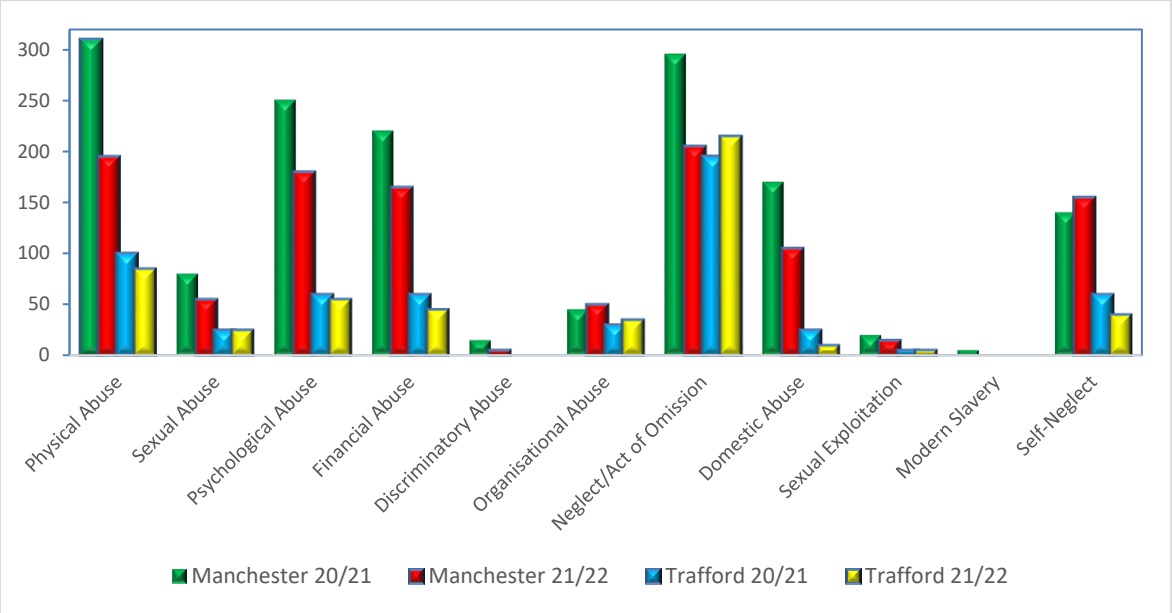
Figure 6: Safeguarding enquiries (no.) according to types of abuse in England, Manchester, and Trafford

Area	Physical Abuse	Sexual Abuse	Psychological Abuse	Finical Abuse	Discriminatory Abuse	Organisational Abuse	Neglect Act of Omission	Domestic Abuse	Sexual Exploitation	Modern Slavery	Self-Neglect
2020/21											
England	40,240	7,410	30,080	28,225	1,395	8,920	61,190	13,880	1,665	525	12,920
Manchester	310	80	250	220	15	45	295	170	20	5	140
Trafford	100	25	60	60		30	195	25	5		60
2021/22											
England	39,000	7.295	28,280	26,130	2.320	11,760	64,330	13,035	1,235	545	13,990
Manchester	195	55	180	165	5	50	205	105	15		155
Trafford	85	25	55	45		35	215	10	5		40

[13] Adult Safeguarding Annual Report 2021/22
[14] Safeguarding Adults, England 2021-22

3.12 **Figures 6,** above and **figure 7** below identify the safeguarding enquiries according to types of abuse completed in England, Manchester and Trafford. Neglect and omission in care/self-neglect were the most recognised forms of adult abuse in England, Manchester and Trafford, with physical and psychological abuse being the second and third most reported category of concern.

Figure 7: Safeguarding enquiries according to types of abuse completed in Manchester and Trafford



Deprivation of Liberty Safeguards (DoLS)

3.13 **Figure 8** below sets out the national data regarding DoLS in England in 2021-22[15].

Figure 8: Deprivation of Liberty Safeguards – the national picture.

- The number of applications has increased by 5.5%, the average growth rate is 4.5% over last 5 years.
- The number of authorised/granted applications has also increased each year, by an average of 11% in the last 5 years.
- 56% of applications that were not granted were due to a change in the individuals' circumstances.
- The average length of time for completed applications was 153 days, 20% of standard applications were completed in statutory timescales.

3.14 A key focus of adult safeguarding for the Trust is ensuring that all patients in MFT hospitals, who lack capacity to consent to care and treatment and who are not free to leave, have had a mental capacity assessment completed and a DoLS application submitted to the LA to ensure that their best interests have been considered in relation to their care arrangements within the legislative framework.

[15] Mental Capacity Act 2005, Deprivation of Liberty Safeguards-2021-22

3.15 In 2021-22 Manchester LA received **3,525** (3,265 in 2020-21) DoLS applications, which included **1730 (**1,585) from acute[16] hospitals. From the number of applications completed **1,210** (2,180) applications were granted and **2,155** (1055) were not. The most common reason for an application not being granted was a change in the person's circumstance. Acute trusts completed the most applications for DoLS compared to other CQC service types in Manchester.

3.16 Trafford LA received **2,180** (2,375) DoLS applications which included **1,055** (1,000) from acute hospitals. From this number **720** (1,250) applications were granted and **1,460** (2,155) were not. The most common reason for an application not being granted was a change in the person's circumstance.

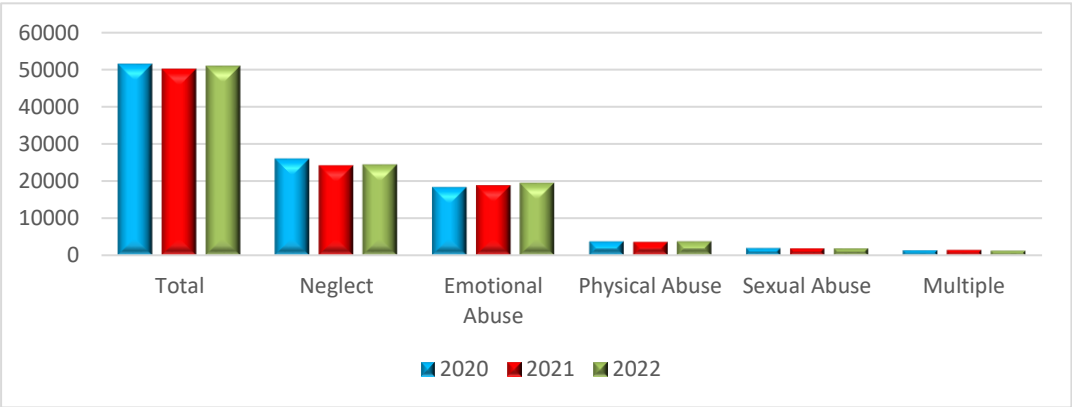
3.17 This year in Manchester and Trafford, the number of DoLS applications from acute hospitals continues to increase, the national data does not indicate the number of acute DoLS applications that are granted but there is a continued pattern that more DoLS are not granted than granted by LAs.

Keeping Children Safe - The National and Local Context in Manchester and Trafford

3.18 On 31st March 2022, **50,920** (compared to 50,010, 2021 the previous year) children in England[17] were the subject of a child protection plan (CPP) due to experiencing or being at risk of significant harm from abuse or neglect. This is a small increase from the previous year (1.8%) and an increased rate at **42.1** per 10,000 children compared to the previous year.

3.19 **Figure 9** below shows the number of children subject to a CPP in each category of abuse and neglect in England in the last 2 years. Child neglect remains the most frequently reported category of abuse with emotional abuse being the second most common category.

Figure 9: Number of children subject to CPP by initial category of abuse and neglect in England in the last 2 years



3.20 A child in need is defined under the Children Act 1989 as a child who is unlikely to reach or maintain a satisfactory level of health or development, or their health or

[16] The national data identies acute hospitals and does not state which Trust made the referral
[17] Characteristics of children in need 2022

development will be impaired without the provision of services, or the child is disabled. On the 31st March 2022[18] there were **404,310 (**388,490) 'Children in Need' (CIN) in England. This is an increase of 4.1% from 2021 and is the highest number since 2018.

3.21 The MSP commitment vision and commitment for children and young people is for:

> "Every Child in Manchester is Safe, Happy, Healthy and Successful.
>
> To achieve this, we will: Be child-centred, listen to, and respond to children and young people, focus on strengths and resilience, and take early action."

3.22 The TSSP statement of purpose[19] to guide work with children, young people and families is:

> "The safeguarding partners and all relevant agencies that work with children and families are committed to ensuring that safeguarding arrangements are of the highest quality, that they consistently promote the welfare and effective safeguarding of children whatever their circumstances".

3.23 As a committed partner, MFT embraces these visions and priorities and we have systems in place to ensure that the unborn, children and young people who receive care from the Trust receive high quality care to protected them from abuse and neglect.

3.24 Manchester and Trafford have a number of children and young people who require services under the Children Act (1989) framework to keep them safe, as either a Child in Need (Section 17) or Child Protection (Section 47) of the Children Act (1989). A robust partnership approach is essential in identifying children and young people who are at risk of, or who are suffering harm, in order to ensure the best protection is afforded to them.

3.25 The most recent data[20] (**Figures 10a and 10b**) outlines how Manchester and Trafford compare statistically in relation to National, Northwest and statistical neighbours' data in respect of the numbers of children who are categorised as CIN or who are on a CPP.

Figure 10a: CIN Statistical Comparison

Area	CIN on 31st March 2020	CIN on 31st March 2021	CIN on 31st March 2022

[18] Characteristics of Children in Need 2022
[19] Trafford Strategic Safeguarding Partnership Annual Report 2021-22
[20] Characteristics of Child in Need 2022

England	**389,260**	**388,490**	**404,310**
North West	**58,080**	**57,670**	**60,390**
Manchester	**5,330**	**5,312**	**5,167**
Liverpool (statistical neighbour)	**4,156**	**4,329**	**4,579**
Trafford	**1,420**	**1,467**	**1573**
Bury (statistical neighbour)	**1,302**	**1,428**	**1,628**

3.26 The CIN statistics identify an increasing number of children in need in England with Trafford following this national trend. In Manchester there has been a decrease in children in need over the last 3 years.

Figure 10b: Children Subject to a CPP Statistical Comparison

Area	Children on a CPP on 31st March 2020	Children on a CPP on 31st March 2021	Children on a CPP on 31st March 2022
England	**51,510**	**50,010**	**50,920**
North West	**7,880**	**7,390**	**7,260**
Manchester	**731**	**564**	**500**
Liverpool (Statistical Neighbour)	**544**	**622**	**611**
Trafford	**205**	**184**	**200**
Bury (statistical neighbour)	**146**	**201**	**230**

3.27 The number of children subject to a CPP has decreased in Manchester significantly, over the last 3 years. In Trafford, the number of children subject to a CPP has increased compared to 2021. It is important to note that this section is based on national data is for 2022, section F of this report will explore 2022-2023[21] Manchester and Trafford data, not yet collated in the national annual statistics.

[21] MSP and TSSP quarterly data sets submitted to Safeguarding Effectiveness Committees

SECTION D

Safeguarding Governance and Accountability

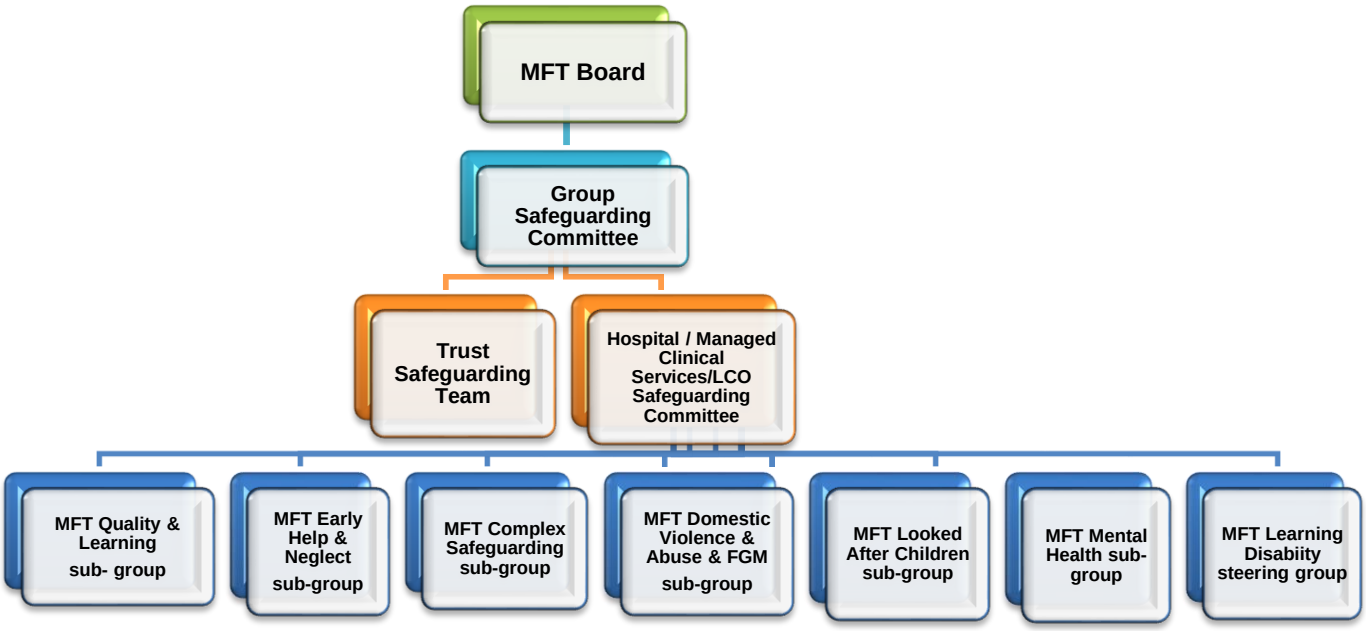
4. Safeguarding Governance and Accountability

4.1 The Group Chief Nurse is the Board Executive lead for safeguarding and is accountable for safeguarding across MFT. The Chief Nurse is supported by a robust senior management and operational structure that ensures both acute and community safeguarding services are aligned in terms of governance and accountability. The Group Deputy Chief Nurse provides strategic leadership, and the Assistant Chief Nurse Safeguarding provides expert leadership across the Trust and supports the Group Deputy Chief Nurse strategically across the partnerships. Hospital/MCS/LCO Directors of Nursing/Midwifery are accountable for local safeguarding governance. The Head of Nursing Safeguarding provides operational leadership across the safeguarding service whilst also contributing to partnership activity to underpin the objectives of the local safeguarding partnerships.

4.2 Effective safeguarding communication and information sharing across MFT is essential to support the Hospitals, MCS and LCOs in the Trust's Group structure, whilst aligning to both Manchester, Trafford, and Greater Manchester safeguarding governance requirements.

4.3 To effectively address the breadth of safeguarding practice, a clear governance structure is in place identified in **Figure 11.**

Figure 11: Safeguarding Governance Structure



4.4 The Group Safeguarding Committee is chaired by the Group Chief Nurse and its thematic sub-groups are chaired by a senior member of the safeguarding team or a Director of Nursing or Associate Medical Director, all groups have representation from all of the Hospitals, MCS and LCOs. Each Hospital/MCS/LCO has a safeguarding committee chaired by the Director of Nursing/Midwifery. The sub-groups and the Hospital/MCS/LCO safeguarding committees are accountable to the Group Safeguarding Committee, which reports through the Trust's governance structure, to the MFT Board of Directors.

4.5 The Trust's named professionals are statutory roles and are responsible for supporting all the activities necessary to ensure that the Trust meets its statutory responsibilities. Named doctors for safeguarding children and looked after children provide leadership, training, and advice to medical colleagues to support the clinical assessment and care of children and young people where there are child protection concerns or children are looked after by the Local Authority. The safeguarding named professionals ensure that the Trust has robust safeguarding policies and procedures in place in line with legislation, national guidance, and the guidance of the MSP/TSSP.

4.6 The following section provides an overview of the MFT Group Safeguarding Committee subgroup activity and the work completed in these thematic work streams during 2022-23.

MFT Quality and Learning Sub-group

4.7 **Purpose of the Group**

The aim of the Safeguarding Quality and Learning Subgroup is to ensure that national and local safeguarding messages influence and inform policy development, training programmes and safeguarding practice across the Trust. The group provides oversight of both single and multi-agency safeguarding audits, inspections, and reviews, the group monitors the implementation and progress of hospital, MCS and LCO safeguarding work plans and monitors implementation of reviews and audit action plans.

4.8 Group Work Streams and Relationships with Multi-Agency Groups

4.9 Key Achievements

- ✓ The group has an established membership and benefits from a good attendance from all of the hospitals/MCS/LCO.
- ✓ All safeguarding policies requiring a 3-year review have been developed, consulted upon and implemented through this group, with a focus this year on reviewing mental health policies in line with the mental health scoping and assurance work completed across the Trust.
- ✓ The group has led the review and implementation of the revised mandatory safeguarding training programme, through a newly developed safeguarding training strategy steering group which reports to the Quality and Learning Subgroup.
- ✓ Learning from safeguarding reviews has been shared and recommendations that require actions for MFT are closely monitored and scrutinised. This year learning has been shared from Manchester Safeguarding Adult Reviews (SAR) Gayle[22], learning review Rayan, Manchester Serious Case Reviews (SCR) Jacob, U1 and P1[23], learning review Jesse, Bury Child Safeguarding Practice Review (CSPR) Isabella[24], Trafford CSPR Michael, Teddy, Wilbur and Peter[25] and Manchester Domestic Homicide Reviews Storm[26] and Louise[27].

[22] Manchester Safeguarding partnership Safeguarding Adult Reviews
[23] Manchester Safeguarding Partnership Child Case Reviews
[24] Bury Integrated Safeguarding Partnership
[25] Trafford Strategic Safeguarding Partnership Learning into practice
[26] Manchester Community Safety Partnership (MHSP) DHR Storm
[27] MHSP DHR Louise

- ✓ Key messages and priorities to and from the safeguarding partnerships have been shared and have influenced safeguarding practice in the Trust. The MSP Self-neglect guidance, Escalation and Resolution process have been shared and incorporated into local policy and practice.

4.10 **Areas for Development**

- Multi-agency safeguarding reviews and MFT safeguarding audits have identified a continued requirement to support frontline practitioners to improve in the consistent application of the MCA and DoLS, this learning has informed the Trust LPS implementation group work plan. There is a plan to further audit MCA and DoLS compliance in 2023/24.
- Hospitals/MCS/LCO work plans consistently report on their local scrutiny and work to improve mandatory safeguarding training compliance, especially for level 3 mandatory safeguarding training. In 2023/24 the MFT Safeguarding Training Strategy will be finalised and launched.
- Learning from reviews this year has consistently highlighted the requirement to promote professional curiosity in frontline workers in recognition and response of safeguarding concerns to promote a multi-agency "Think Family" assessment and safeguarding plan. The group has and will continue to prioritise how these messages can be embedded at the frontline through the provision of effective training, supervision, policy and practice development.
- The hospitals/MCS/LCO have exception reported in their safeguarding work plans that there has been an increase in the volume and acuity of patients admitted with mental health concerns or who are displaying distressed behaviours and are awaiting a mental health hospital admission or LA placement. This work has informed the partnership response to the Greater Manchester Children in Crisis framework and supported implementation of updated MFT mental health policy and guidance.
- The group has continued to review messages from safeguarding assurance visits which has informed the development of an unannounced safeguarding assurance visit guidance framework which will implemented in 2023/24.

MFT Early Help and Neglect Sub-group

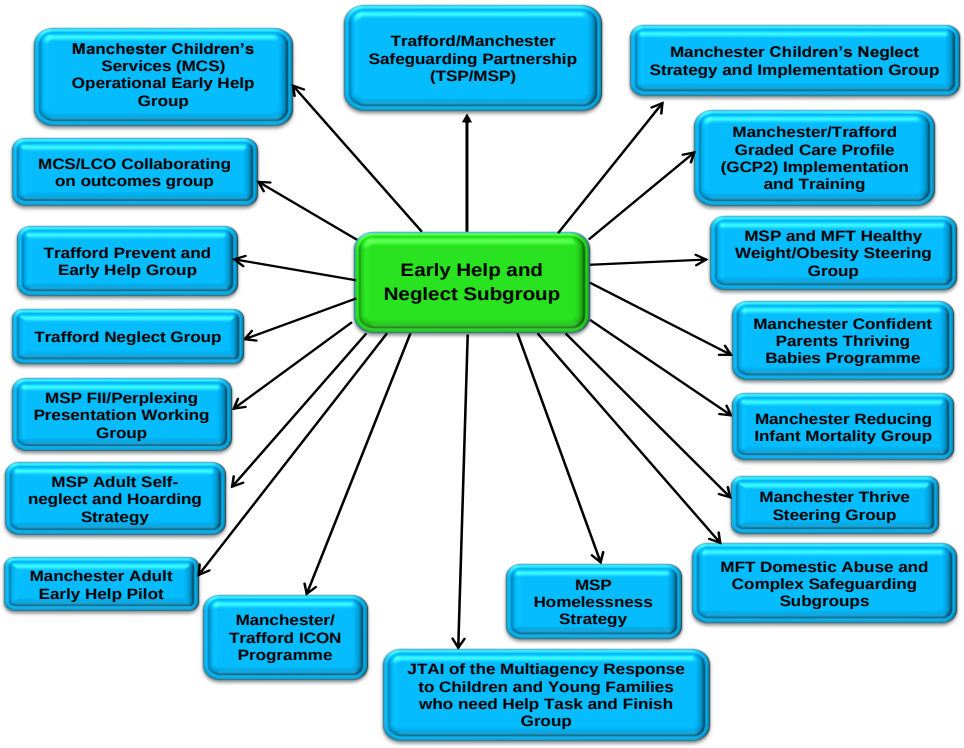
4.11 **Purpose of the Group**

The remit of the subgroup is to ensure that the Early Help and Neglect agenda is embedded across hospitals, MCS and LCOs, to ensure high quality assessments and information sharing in line with multi-agency safeguarding partnership standards. This group's remit is to:

- Ensure local practice and procedures are reflective of the national messages, the Manchester and Trafford Safeguarding Partnerships strategic and operational groups and learning from safeguarding reviews.
- Develop and implement training and briefings for hospitals/MCS/LCO in line with Early Help and Neglect requirements.
- Ensure that health care professionals have the tools and support to work sensitively to undertake assessments and care plans in partnership with children, young people, parents, adults at risk and other professionals.
- Ensure that Early Help support, is accessible to all service users.

- Seek assurance on the hospital/MCS/LCO compliance with safeguarding legislation and regulation in relation to early help and neglect.

4.12 Group Work Streams and Relationships with Multi-Agency Groups



4.13 Key Achievements

- ✓ The areas for development from 2021-22 provided the framework for the proposed work for 2022-2023.
  - Contribution to development, dissemination, and implementation of Manchester Children's Neglect Strategy (2021-2024). The Manchester Tackling Neglect Change plan was established with input from the Early Help and Neglect sub-group membership.
  - Joint working with representatives to the Manchester Early Help hubs in providing training updates to hospitals, MCS, LCO.
  - Updating the sub-group of the Navigator Project, promoting the learning from Serious Youth Violence Thematic review[28] illustrating the value of early help in tackling very serious neglect and subsequent youth violence across Manchester and Trafford.
- ✓ Policy, Procedure and Guidance contribution to the development, dissemination and implementation of MSP Self-Neglect and Hoarding Guidance 2022-2025 and TSSP Neglect Strategy.
- ✓ Learning has been shared with local safeguarding committees from published MSP reviews, Adult Self-Neglect Thematic Review, SAR Gayle, learning review Rayyan[29], through presentations and circulation of published 7-minute briefings.

[28] Manchester Safeguarding Partnership Child Case Reviews
[29] Manchester Safeguarding partnership Safeguarding Adult Reviews

- ✓ Training – the group promoted attendance at the Manchester Self-Neglect Conference with the group taking forward the complexity and challenges associated with completing mental capacity assessments including an analysis of executive functioning. The group contributed to the Trafford Neglect Conference and implementation of the National Society for the Prevention of Cruelty to Children (NSPCC) Graded Care Profile.
- ✓ There has been improved attendance and contribution from subgroup representatives with evidence in work plans of how the messages from policy, procedure and guidance is shared with the local safeguarding committee and ward level of Early Help resources available.
- ✓ The group has worked closely with other MFT safeguarding subgroups as child neglect and adult self-neglect are interlinked with many other safeguarding workstreams including the Looked After Children subgroup (SAR Gayle and Learning Review Rayyan), Domestic Abuse subgroup, Complex Safeguarding (Navigator Project), Quality and Learning subgroup, Reducing Infant Mortality group and Healthy Weight Strategy group.

4.14 **Areas for Development**

- To ensure recommendations and lessons learned in relation to Early Help and Neglect from local and national child safeguarding practice reviews, safeguarding adult reviews are implemented across hospitals/MCS/LCO.
- For the hospitals/MCS/LCOs to further develop their provision of evidence of Early Help and work in tackling neglect within their safeguarding work plan. The safeguarding team will support the hospitals/MCS/LCOs to further develop their provision of evidence within their safeguarding work plan, supporting education and development regarding early help and neglect. This will inform preparation and evidence collation for the expected Joint Target Area Inspection (JTAI) of multi-agency response to children and families who need help[30].
- Continued contribution to the Manchester Safeguarding Partnership's Child Neglect Strategy 2021-24 and Neglect Change Plan to agree the partnership approach to the identification of neglect and associated training. This will then inform the local training offer with the plan to develop an MFT continuing professional development Early Help and Neglect e-learning package.
- Further development and testing of a child neglect early assessment tool to support the use of the Graded Care Profile 2[31] tool which supports practitioners in the identification of neglect in children.
- To continue to develop of workstreams to support practitioners working with children and young people who are experiencing childhood obesity in the context of neglect.
- Prioritise making safeguarding personnel and hearing the voice of the child/young person within early help and neglect practice.

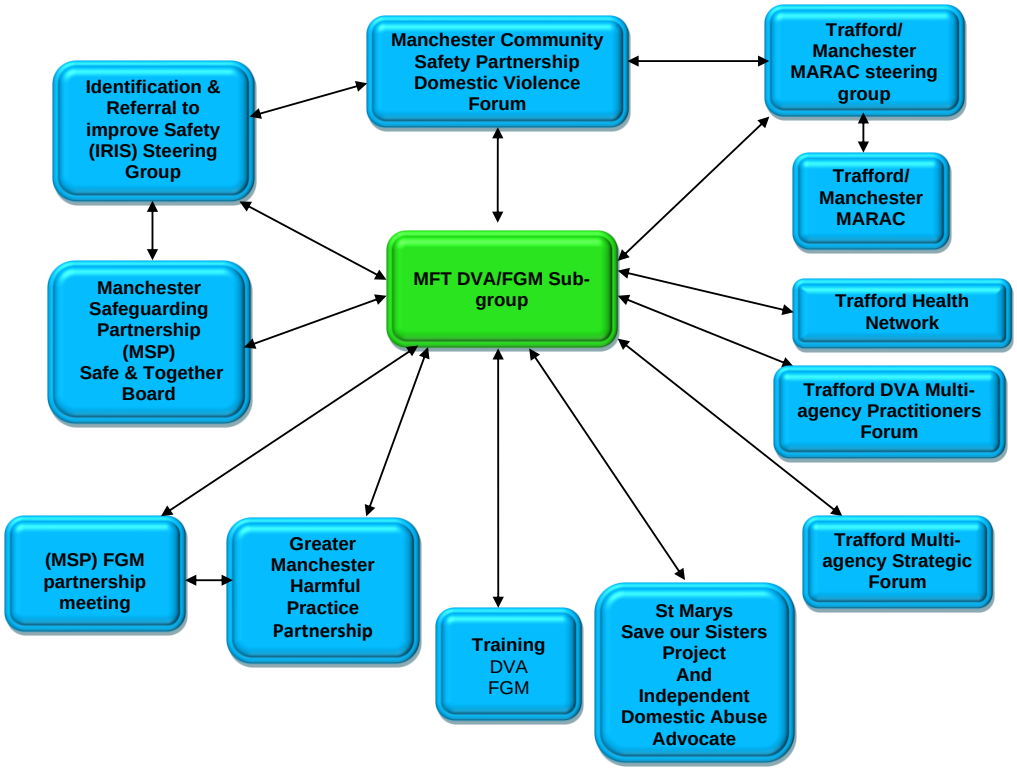
[30] Joint targeted area inspection of the multi-agency response to children and families who need help
[31] Graded Care Profile Tool 2

MFT Domestic Violence and Abuse (DVA) and Female Genital Mutilation (FGM) Subgroup

4.15 **Purpose of the Group**

The DVA and FGM subgroup develops policy, practice and training, and cascades key messages and learning from local and national reviews/messages to improve the response in the recognition, risk assessment and safeguarding of victims and survivors of DVA and FGM. The membership of the group ensures that messages from operational and strategic domestic violence and FGM groups in Manchester, Trafford and Greater Manchester inform and influence practice across the Trust.

4.16 **Group Work streams and relationships with multi-agency groups**



4.17 **Key Achievements**

- ✓ The DVA and FGM Subgroup chair submitted a report to the Group Safeguarding Committee which provides an overview of the Home Office Statutory Guidance – Domestic Abuse Published July 2022[32]. This report outlined the key messages for MFT including MFT and MSP response.
- ✓ The DVA and FGM Subgroup has reviewed the key findings from a thematic CSPR analysis[33] which informs practice around multi-agency safeguarding and DVA. The key recommendations and learning will be shared in safeguarding training, supervision, advising staff and through the subgroup and safeguarding newsletter.
- ✓ Messages from two local DHRs published in 2022/23 have been shared with the group for dissemination across the hospitals/MCS/LCO, using presentations, 7-minute briefings and the safeguarding newsletter.

[32] Home Office Statutory Guidance – Domestic Abuse
[33] Multi-agency safeguarding and domestic abuse

- ✓ The DVA and FGM Subgroup chair has set the subgroup agenda to include information and current themes in DVA and FGM e.g., including guest speakers and patient stories.
- ✓ The chairs of the subgroup have contributed to national Home Office and NHSE led domestic abuse mapping exercise (Whole Health DA mapping- March 2023, NHSE DVA Audit survey- February 2023), which explored resources, partnership working, training and service delivery.
- ✓ The chairs presented at the MSP domestic abuse scrutiny event on the work of MFT response to DVA and how this links into the Manchester Community Safety Partnership and safeguarding adults and children across the city. In addition, MFT Senior Specialist Safeguarding Nurse presented an overview of DVA work at MFT/MLCO/TLCO on an "Away Day" of Manchester DVA Forum.
- ✓ The subgroup has received regular updates and information for members leading the Northern Sexual Health Service on "The Advise" Project which has been commissioned for another year. The project involves staff completing routine enquiry on DVA and sexual violence to all service users who then have a bespoke specialist domestic abuse service response offered on disclosure of DVA.
- ✓ The subgroup has contributed to a Manchester Community Safety Partnership workstream on Greater Manchester Multi-Agency Risk Assessment Conference (MARAC). This work has involved working closely with key DVA partners to look at the whole process used to manage high risk DVA and systems used to identify and support victims across the partnership.
- ✓ The subgroup has contributed to an MSP workstream on Domestic Abuse and Child Concern (DVACC). Senior professionals from all key agencies have reviewed the effectiveness of the current DVACC meetings which take place daily in the Manchester Advice and Guidance Service (AGS) or the "front door" to children'
- ✓ The new level 3 mandatory safeguarding training includes a DVA module which includes raising awareness of the role of frontline professionals in the recognition and response to DVA.
- ✓ Specialist training on risk assessment for young people impacted by domestic abuse was commissioned and co-delivered with Safe Lives[34], 19 staff from SARC, TLCO, sexual health and LAC nurses who have face to face contact with vulnerable young people attended.

4.18 **Areas for Development**

- To continue to ensure the subgroup work plan is informed by the Manchester Community Safety Partnership DVA Forum to deliver the three key priorities of the Manchester Domestic Abuse Strategy[35] which are:
  1. Prevent abuse and promote healthy relationships.
  2. Identifying abuse and intervening.
  3. Support victims and recovery.
- To continue to strengthen links with the TSSP and Trafford Community Safeguarding Partnership Strategic groups.
- To ensure learning outcomes from local DHRs are represented in the subgroup work plan:

[34] www.safelives.org
[35] Manchester Domestic Abuse Strategy

DHR Louise

1. Raised awareness of culturally competent practice.
2. Awareness of the barriers to seeking help and support for black and ethnic minority communities.
3. The role of the faith community in addressing domestic abuse.

DHR Storm

1. The impact of coercive control on mental health.
2. Links between suicide and domestic abuse.
3. What support is offered when a parent no longer has the care of their children.
4. How agencies locally and nationally can communicate effectively to support those fleeing abuse.

- To offer specialist DVA training according to risk and need.

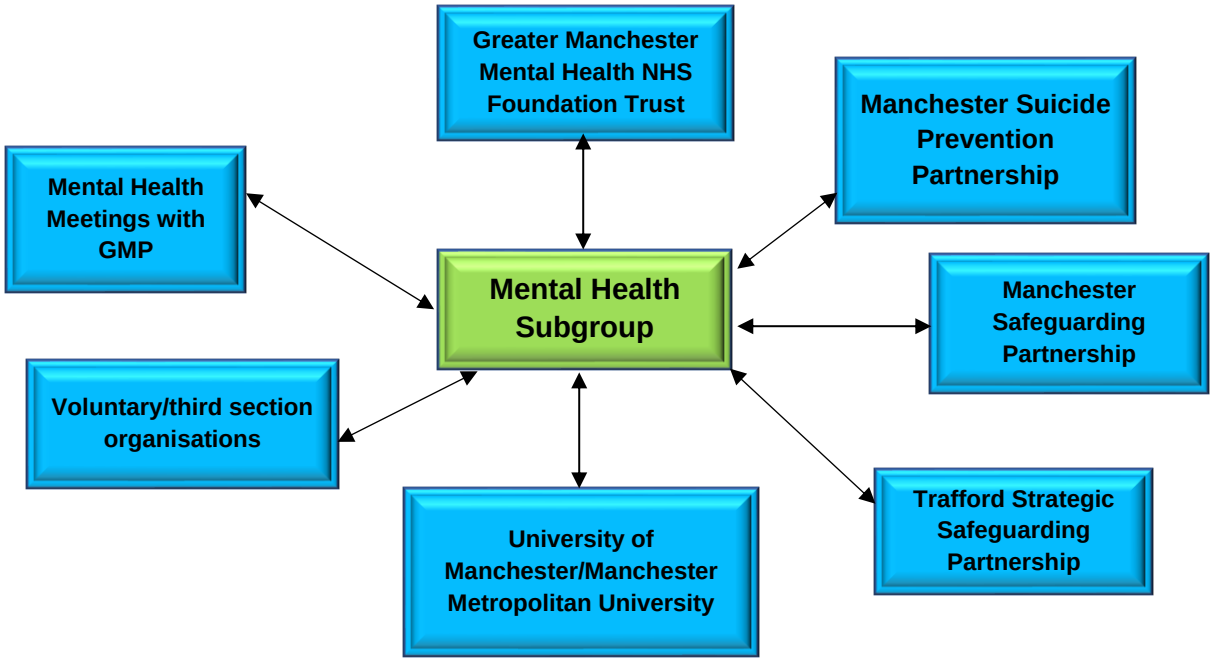
Mental Health Safeguarding Subgroup

4.19 **Purpose of Group**

The purpose of the Mental Health Safeguarding Subgroup is to have oversight of activities relating to mental health across MFT to support the delivery of the Mental Health Strategy, providing assurance of the effectiveness of systems in place in relation to the Mental Health Act 1983, including the Code of Practice 2015, and the Mental Capacity Act 2005, delivered through:

- The Greater Manchester Mental Health (GMMH)/MFT Mental Health Liaison Operational Procedure (based on the National Service Specifications (Manchester Mental Health Liaison)
- Trust Policies and Procedures
- The Mental Health Training programme.

4.20 **Mental Health Safeguarding Group Work Streams and Relationships with Multi-Agency Groups**



4.21 **Key Achievements**

- ✓ A report was provided on the scoping exercise[36] completed to review systems, policies, and procedures in place to support staff to provide the best possible care and treatment according to legislation, national guidance, regulatory, and audit standards particularly focussing on CQC regulatory standards of monitoring the Mental Health Act (MHA). The scoping identified evidence of systems and processes in place across MFT that demonstrate implementation of national standards and recommendations.
- ✓ Development and consultation of MFT Mental Health Strategy to ensure parity of esteem for patients with a mental health condition.
- ✓ A Mental Health Action plan has been developed.
- ✓ In response to the scoping exercise and action plan updated terms of reference (TOR) have been agreed by members which focus on development and delivery of the Mental Health Strategy..
- ✓ The Mental Health Act (MHA) policy has been updated, which has been streamlined for clarity to support Trust compliance with the legal framework and protection of patient rights.
- ✓ Greater Manchester Police attendance at the group has enabled greater partnership working with hospitals/MCS/LCO to support patients and staff.
- ✓ Discussions at the group have improved support with MHA appeal process to support patients and staff should an appeal be requested by a patient.
- ✓ Mental Health level 2 and 3 training have been developed and are now available on the Trust Learning Hub.
- ✓ The Prevention & Management of Restrictive interventions policy has been reviewed there is an ongoing task and finish group to agree a strategy for the training of clinical staff in reducing restrictive interventions.
- ✓ MCA/DoLS training is now available across all sites, this includes E-Learning, face to face and via Teams
- ✓ The Suicide Prevention policy was relaunched to continue to promote the integrated care pathway for patients at risk of suicide or self-harm, promote the environmental ligature risk assessment and ligature incident and risk management train the trainer programme across all hospitals/MCS/LCO in the Trust.
- ✓ The group has reviewed the response to the CQC questions to MFT enquiring about the safety within MFT Emergency Departments (ED) when patients attend with mental health difficulties
- ✓ Learning from Safeguarding Adult Reviews due to be published in 2023-24 has been shared which identifies the importance of joint documentation between the Mental Health Liaison Team and MFT staff being able to access and document risk assessments and care plans. The Hive electronic patient record has enabled shared documentation.

4.22 **Areas of Development and Priorities for 2023-2024**

- To launch the MFT Mental Health Strategy in October 2023 and to develop an implementation plan in collaboration with mental health providers and multi-agency partners

[36] Nursing, Midwifery and Allied Health Professional Board Paper November 2022, To provide an overview to Professional Board members following a scoping exercise of mental health care across the Trust.

- To ensure involvement of service users and carers to offer expert advice on all the developments at MFT, initially with the Mental Health Strategy.
- Continued support for MRI and GMMH liaison leads to develop plans to migrate to the new ED, with agreed contingencies in place to ensure environmental safety of mental health patients awaiting mental health assessment.
- Continued recognition of how Hive can support patients and staff in improving and monitoring of care standards for patients with a mental health condition.
- A task and finish group will formulate recommendations for a training plan for clinical staff in reducing restrictive interventions in line with Reducing Restrictive Interventions Network (RRN) standards[37].

Learning Disability and Autism Steering Group

4.23 **Purpose of Group**

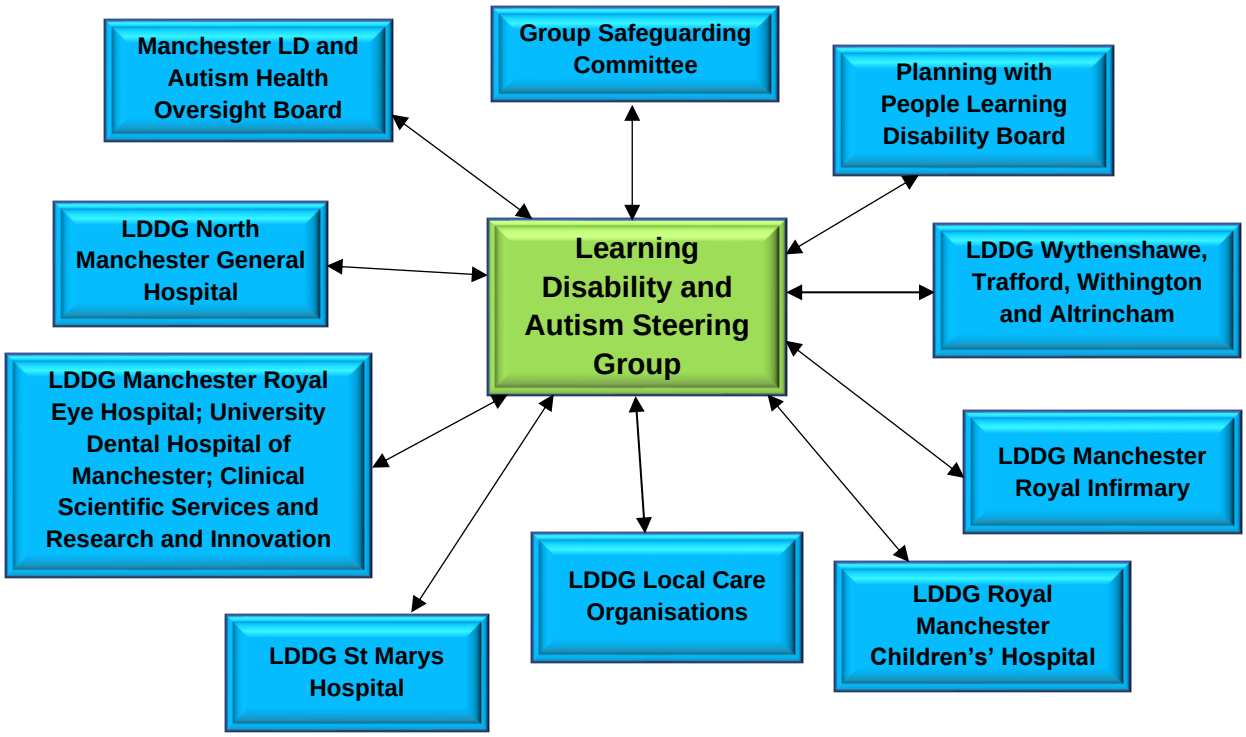
The purpose of the Learning Disability and Autism Steering Group (LDASG) is to oversee and drive both assurance and improvements for people with a learning disability (LD) and/or autism, their families and carers accessing healthcare services across MFT via the Hospitals, MCS and LCO's LD and Autism Delivery Groups (LDADG).

This includes:

- Setting the strategic direction within the Trust for the care received by people living with a LD and/or autism across all services.
- Responsible for reviewing standards for people with a LD and/or autism in line with national and local policy, guidance and standards.
- Ensure robust, effective arrangements are in place to meet the standards by NHS Improvement Guidance, National Institute for Health and Care Excellence (NICE) guidance and local standards.
- Provide oversight of LD and/or autism policy development, in collaboration with recognised patient experience/carer forums.
- Provide oversight for all Hospital/MCS/LCOs LD and/or autism workplans, to provide assurance that co-ordinated work takes place across all areas.
- Co-ordinate and share best practice across the Trust, including dissemination of learning and ensuring LD and/or autism delivery group action plans are progressed in line with agreed time scales.

[37] Restraint Reduction Training Standards

4.24 **Group Work Streams and Relationships with Multi-agency Groups**



In Quarter 4 2022-2023 four task and finish groups were established to align to the four standards within the Trust strategy (Respecting and Protecting Rights; Inclusion and Engagement; Workforce; and Learning Disability Services Standard). The aim is to provide a standardised approach aligned to the strategy utilising published guidance and documents. The task and finish groups have representation from Hospitals/MCS/LCOs.

4.25 **Key Achievements**

- ✓ MFTs LD and Autism Strategy 'Our plan for people with learning disabilities and/or autism, their families and carers 2022-2025 was launched during LD awareness week (20th – 26th June 2022). In addition to the launch of the strategy, LD and Autism packs were also launched across Hospitals/MCS and a number of activities and celebrations took place across Hospitals/MCS/LCOs.
- ✓ A reasonable adjustment assessment tool has been implemented in all hospital/MCS in-patient areas. Since implementation there has been an increase in completion of reasonable adjustment care plans and improvement of care plans reflecting patients' needs.
- ✓ Easy read resources are available on the Trust intranet for staff to access.
- ✓ Patients with LD can be identified via the Hospital/MCS electronic IT system Hive and the LCOs electronic system EMIS.
- ✓ LD Champions are in place across Hospitals/MCS/LCOs with further work taking place to ensure they are in all wards/service/departments and have received bespoke training and education. This will be incorporated into the Oliver McGowan training with rollout expected during 2023.

- ✓ 128 staff members have attended the two-day course on LD awareness facilitated and developed by Salford University co-delivered by Supporting People in Community Employment (SPICE) which involves people with lived experience.
- ✓ The LDSG monitors and reviews actions against LeDeR reports with lessons learnt are cascaded through local LDDG.
- ✓ The LDSG receives quarterly reports relating to incidents and complaints where it is reported that the person involved has a LD, themes are shared and lessons learnt are cascaded to wider services through the local LDDG.
- ✓ "Restore 2 mini[38]" is being piloted in community, where carers are trained to pick up early signs of deterioration, and knowledge to contact community services to implement.
- ✓ Reasonable adjustment care plans and passports are being shared between hospital and community teams, so teams and carers can benefit from these.
- ✓ A draft Trust policy has been developed for patients with a LD and Autism in Hospital to provide clear guidance for staff on how to support people with LD and Autism.
- ✓ Members of RMCH's Focused Support Team are members of the National Paediatric LD/Autism Spectrum Disorder (ASD) Acute Liaison Network.
- ✓ Hospitals/MCS LDADG have undertaken an assessment against the CQC Report (2022) Experiences of being in Hospital for people with a learning disability and autistic people[39].
- ✓ Focus continues on collecting patients with LD and/or autism experience/ feedback. There has been agreement from the Patient Experience Team to support the Inclusion and Engagement task and finish group.
- ✓ Notification process and alerts of LeDeR deaths has been implemented. A LeDeR Standard Operating Procedure (SOP) has been developed identifying the roles and responsibilities of the Bereavement Team, Specialist Safeguarding LD Team, Clinical Governance Team, Mortality Lead and Consultants completing the Structure Judgment Reviews for the LeDeR process.
- ✓ The Patient Experience Team have agreed that all patient volunteers in MRI will wear a hidden disabilities 'here to help' sunflower badge and will receive training on the scheme as part of their induction.
- ✓ The MRI Quality Team has joined forces with a group of GPs and the Patient Experience Team and have created a video tour of outpatient and elective areas with pre-operative, day case and adult theatres being planned.
- ✓ Following feedback from the Patient and Carers Forum picture/visual patient hospital appointment letters have been developed.
- ✓ Representatives from the LDASG attend the Manchester LD and Autism Health Oversight Board which reports into the Greater Manchester (GM) LeDeR and Good Health and the Manchester Planning with People Learning Disability Board to ensure system-wide working.

[38] Restore2 Programme
[39] Experiences of being in Hospital for people with a learning disability and autistic people' CQC 3rd November 2022

4.26 **Areas of Development**

- Plan implementation of the Sunflower scheme across MFT to recognise hidden disabilities and develop work to improve patient experience for these individuals.
- Task and finish groups to identify areas of good practice that can be implemented across all Hospitals/MCS/LCOs and determine how MFT as system partners can evidence the Manchester LD and Autism Health Oversight Board priorities .
- Harmonisation of the MFT Enhanced Observations for Care Policy and North Manchester General Hospital (NMGH) Enhanced Patient Observation Policy.
- Children's Services and Community Adults LD Team Joint Working Protocol has been developed to support joint working when there is a parent with a LD and is part of the Think Family approach to support joint working in Manchester. The protocol initially includes the social care offer with acknowledgement that other system partners need to be included.
- A short-term task and finish group will be established with Employee Health and Well-being support to look at reasonable adjustments for staff with a known autism spectrum disorder, in order to allow them to perform their duties. Mental health first aiders will also be involved in the discussions.
- Each Hospital/MCS/LCO has a work plan, and these are monitored/reviewed by the LDASG and any shared learning from developments is cascaded.
- The Hive safeguarding group will support implementation of flagging patients with autism to better inform strategies to deliver the right quality of care for their needs.
- An audit of the use of patients' hospital passports has been undertaken at NMGH with audits to be completed on other hospital sites.
- Provide support and resources to inpatient areas to ensure people with a LD access their annual health check in the community. Community Adult LD Service to ensure they establish if patients referred into the service have had an annual health check.
- Review of Patient and Carer Forum. Further work to increase the number of patients/carers attending the forum.
- Review and relaunch of planned and emergency admission pathways.
- The Specialist Safeguarding LD Team will attend Mortality Group meetings for each hospital site to contribute to the discussions relating to LeDeR and share feedback from the completed Best Practice Reviews.

MFT Complex Safeguarding Sub-Group

4.27 **Purpose of the Group**

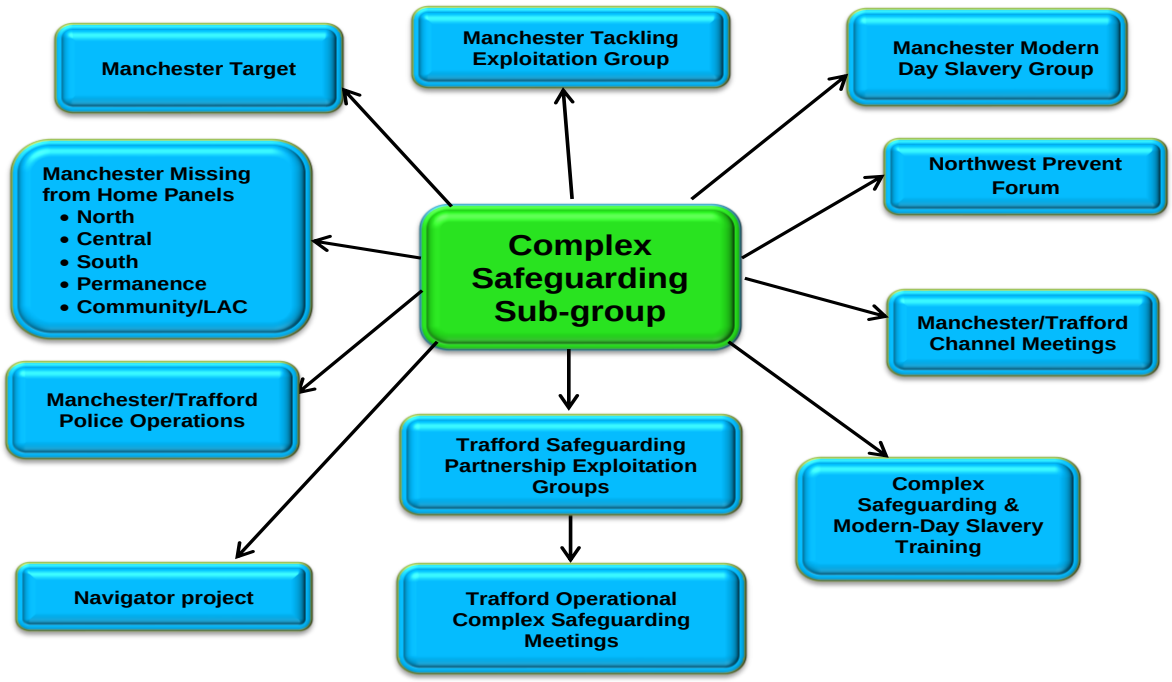
MFT has a complex safeguarding subgroup with trust wide representation. A complex safeguarding work plan was developed against Manchester Safeguarding Partnership (MSP) Complex Safeguarding Strategy 2020-2023. The subgroup has been a platform for promoting and implementing training, policies, and the exploitation risk indicator checklist (RIC) for children. Further exploration has taken place in relation to whether a RIC is required for adults.

The remit of the Complex Safeguarding Subgroup is to ensure that all practitioners understand their individual and corporate responsibility and accountability regarding safeguarding adults and children from all forms of exploitation.

The subgroup members communicate information and share best practice in relation to the Complex Safeguarding agenda, this includes, but is not exhaustive:

- Exploitation (sexual/criminal/adult/child)
- Modern slavery
- Vulnerability and organised crime
- Serious Youth Violence
- Manchester Complex Safeguarding Hub and Trafford Complex Safeguarding Team SHINE
- Prevent programme
- Children and young people Missing from home

4.28 **Group Work Streams and Relationships with Multi-Agency Groups**



4.29 **Key Achievements**

- ✓ Named Practitioner Adult Safeguarding recruited as deputy chair to ensure the agenda has a balanced child and adult focus.
- ✓ Complex safeguarding work plan 2022/2023 developed and mostly completed.
- ✓ A feedback template has been developed and the expectation is for representatives to share what work they have been doing within their services to promote an awareness of exploitation and how the messages from the subgroup are disseminated in their safeguarding committees. This provides assurance to the chair that messages from the subgroup are being shared.
- ✓ The Exploitation Risk Indicator Checklist (RIC) for children and young people to support frontline staff in identification and response to DVA has continued to be promoted. Representatives were encouraged to display posters in their departments during the exploitation weeks of action. This work was informed by the Trafford Senior Specialist Nurse Complex Safeguarding who shared a powerful and honest YouTube clip of a young person's voice around the impact of exploitation and what young people expect from professionals.

- ✓ The new level 3 mandatory safeguarding training includes a complex safeguarding module which includes an example RIC with what information to include.
- ✓ The Navigator Project Coordinator is a representative of the group and provides regular updates and promotes the process for both acute and community referrals. The coordinator also contributes to the MFT quarterly complex safeguarding health report. The Navigator Project is a youth led violence reduction project commissioned by Greater Manchester Combined Authority (GMCA) Violence Reduction Unit. Navigators are based in the emergency departments at MRI and RMCH.
- ✓ Messages from the Joint Targeted Area Inspection (JTAI) of Cheshire East Findings – Criminal Exploitation of Children[40] were shared. Following this report, the MFT Child Sexual Exploitation (CSE) Specialist Nurse was approached by other trusts to share the MFT Exploitation RIC
- ✓ Representatives were approached to contribute to the MSP Complex Safeguarding Challenge Event in October 2022 which had a focus on transition to adult services.
- ✓ Lessons from a recent publication of the Joint Trafford and Manchester CSPR of serious youth violence were shared at the March 2023 subgroup[41]
- ✓ Prevent training compliance paper is a standard agenda item and an action for representatives to ensure there is an action to address through their safeguarding committees.

4.30 **Areas for Development**

- The work plan will have an increased adult safeguarding focus.
- To promote increased awareness and application of the child exploitation RIC and to repeat a review of its use in quarter 3.
- To strengthen feedback and assurance by representatives in relation to promotional work to increase awareness of the indicators of exploitation and safeguarding response.

Our Children (Looked After Children) Subgroup of Group Safeguarding Committee

4.31 **Purpose of the Sub-Group**

The remit of the subgroup is to ensure that the key areas of the looked after children agenda are embedded in all services in MFT hospitals/MCS/LCOs; these include:

- Service delivery and practice development
- Quality of Statutory health assessments
- Voice and Influence of 'looked after children'
- Partnership work and key messages from the Corporate Parenting Cooperative, Looked After Children Strategic Board and multi-agency subgroups.

4.32 **Key Terms of Reference**

- Ensure looked after children policy, strategy and guidance is disseminated across all hospitals/MCS/LCOs
- Develop and implement training and briefings for hospitals/MCS/LCOs in line with looked after children requirements
- Develop policies and guidelines

[40] JTAI Cheshire East Criminal Exploitation of Children
[41] Manchester Safeguarding Partnership Child Case Reviews

- Seek assurance that looked after children priorities are known and understood, including statutory requirements across hospitals/MCS/LCOs.

4.33 **Group Looked After Children Workstream**

4.34 **Key Achievements**

- ✓ The Our Children subgroup has seen consistent representation from the hospitals/MSC/LCOs.
- ✓ Improved awareness of looked after children amongst the health teams across the MFT workforce.
- ✓ Quarterly health reports are produced within the sub-group to provide assurance of compliance with statutory requirements.
- Development and implementation of a comprehensive training package for professionals including community and acute providers to inform the health needs of looked after children, their journey throughout the looked after process and the professional's roles and responsibilities in achieving the best outcomes.

4.35 **Areas for Development**

- Continue to share and raise awareness of national and local emerging themes and information on looked after children.
- Continue to raise awareness and ensure ongoing delivery of training packages for health professionals to inform of the health needs of looked after children, their journey throughout the looked after process and the professionals' roles and responsibilities in achieving the best outcomes.
- Work in collaboration with key partners to improve the health outcomes for looked after children.
- Review and develop strategies to improve performance against KPIs, including improved reporting on care leaver summaries
- To promote strategies to support children and young people who are looked after to achieve a healthy weight.

SECTION E

Partnership Working

5. Partnership Working

5.1 MFT Contribution to Manchester Safeguarding Partnership (MSP) and Trafford Strategic Safeguarding Partnerships (TSSP)

MFT is fully committed to multi-agency working for both adult and child safeguarding, Our staff are committed to playing an active role in the safeguarding partnership activity at all levels, and to contributing to the wider work of the partnerships by ensuring that feedback from multi-agency sub-groups and lessons from CSPRs and safeguarding adult reviews (SAR) are embedded into practice.

5.2 MFT Progress against Manchester and Trafford Strategic Safeguarding Partnership Priorities and Strategic Objectives 2022-2023

In the 2020-2021 MFT Safeguarding Annual Report, the Trust committed to ensuring that the strategic objectives of the MSP and TSSP were clearly embedded in the safeguarding agenda across MFT. Evidence of how this was achieved can be found in **Figure 12**.

In February 2023, TSSP launched their new safeguarding priorities and it is anticipated that MSP will publish revised priorities in 2023, these will inform the MFT safeguarding reporting in 2023-24.

Figure 12: MFT Achievements against Manchester and Trafford Strategic Safeguarding Partnership Objectives

Safeguarding Priority	Partnership	MFT Response
Neglect Child Neglect, Wilful Neglect and Self Neglect **Early Help and Prevention**	**Manchester Safeguarding Partnership (MSP)** **Trafford Strategic Safeguarding Partnership (TSSP)**	**MFT has an Early Help and Neglect Safeguarding Subgroup with trust wide representation that oversees practice around neglect**. The MFT Early Help and Neglect sub-group work plan 2021-2023 was informed by the MSP and TSSP multi-agency child neglect strategies and implementation plan. MFT has representation on MSP and TSSP neglect sub-groups. The MFT Early Help subgroup has continued to develop the implementation of the neglect strategic workstream through. • Development of a draft MFT child neglect screening tool • Supporting staff in the use of the NSPCC Graded Care Profile (GCP) 2 screening tool with patient stories presented to evidence impact of the tool's effectiveness. MFT have identified practitioners from TLCO 0-19 service and the Trafford Safeguarding Community Team who will support with delivering the multi-agency GCP2 training • Contribution to the MSP adult self-neglect thematic review • Participation in adult and child safeguarding reviews with associated delivery of learning packages (MSP Learning Review Rayyan, SAR Gayle, TSSP CSPR Michael) • Contribution to the development, dissemination and implementation of the MSP Self Neglect and Hoarding Guidance. • Promotion of Managing High Risk Together process. • Contribution to the TSSP child neglect conference.

		• Promoting attendance across MFT at the MSP Adult Self Neglect Conference • Supporting the identification and development of MFT Neglect Champions • Contributing to the MSP multi-agency audit. • Trafford Safeguarding Team has delivered multi-agency training on Obesity and Neglect for GP's and Obesity and Neglect Training for partner agencies. • Trafford multi-agency First Response Steering Group has been established to provide TSSP oversight in the delivery and development of First Response Service Trafford's Integrated Front Door (IFD), ensuring children and families receive the right services at the right time to ensure their needs are met and children are safeguarded. MFT Safeguarding and TLCO Strategic leads are represented at the group to ensure joint strategic ownership for the outcomes and success of the IFD incorporating the wider Early Help offer. • The MFT task and finish group focusing on the JTAI Joint targeted area inspections to focus on early help for children and families has informed the refresh of the Manchester Early Help Strategy.
Mental Health	**MSP**	**MFT has a Trust wide Mental Health Subgroup.** • In November 2023 a scoping exercise was completed to review systems, policies, and procedures in place to support staff to provide the best possible care and treatment according to legislation, national guidance, regulatory, and audit standards particularly focussing on CQC regulatory standards of monitoring the Mental Health Act.This has informed the development of the MFT Mental Health Action plan and draft MFT all age Mental Health Strategy.. • The acute safeguarding team has worked with hospital/MCS's, legal services and security services to operationalise the Trust's ratified guideline Children and Young people who are medically fit for discharge but with no place to be discharged to, developed in response to the Greater Manchester (GM) Health and Social Care Children in Crisis Support and Escalation Framework. • The Mental Health Safeguarding team have developed a Mental Health mandatory level 2 and continuous professional development (CPD) level 3 eLearning module which are available on the MFT learning Hub. • Following learning from Safeguarding Adult Reviews and serious incidents the use of the environmental ligature risk assessment tool has been promoted and training offered on the ligature risk assessment and ligature incident management across the Trust with the train the trainer programme launched at NMGH.

Domestic Violence and Abuse	**TSSP**	**MFT have domestic violence and abuse safeguarding subgroup with trust wide representation which oversees and reviews the delivery of domestic abuse training policy and practice.** • Representatives from the MFT group attend the Manchester and Trafford community safety and safeguarding partnership strategic and operational domestic abuse groups. Trafford Community Safeguarding Team have contributed to the TSSP Domestic Abuse round table events. The safeguarding team have contributed to multi agency workstreams in Manchester to review referrals of victims/survivors of high risk domestic abuse. MARAC referrals remain high across Manchester with some wards in the city (Moston, Newton Heath, Harpurhey, Gorton) consistently being in the top 10 highest levels of domestic abuse in the country. • In St Marys women who disclose domestic abuse and violence are offered support from the onsite Independent Domestic Violence Advocate as part of our partnership working with Midwifery and Domestic Abuse Support Service. • Mandatory and bespoke CPD domestic violence and abuse training is delivered in MFT. Recognition and response to domestic abuse is included in the mandatory safeguarding level 3 new training programme. In 2022-23, **229** MFT practitioners attended bespoke domestic violence and abuse training. • Specialist Safe Lives[42] training for MARAC chairs and training to support professionals in completing risk assessments for domestic abuse in young people has been delivered.. • MFT supported the "16 Days of Action, annual campaign from 25th November to 10th December", raising awareness around domestic abuse and violence against women and girls. All departments across the MFT were asked to participate and share resources provided by MFT safeguarding team. This included regular tweets, Facebook notifications, posters and information via staff intranet links.
Exploitation/Complex Safeguarding	**MSP** **TSSP**	**MFT has a complex safeguarding subgroup with trust wide representation. A complex safeguarding work plan was developed against the MSP Complex Safeguarding Strategy 2020-2023.** • The Navigator scheme to support young people affected by knife crime and serious violent assault is available across acute and community services. • Trafford and Manchester community safeguarding teams have a complex safeguarding/CSE specialist nurses post as part of the multi-agency complex safeguarding teams. • Mandatory and bespoke complex safeguarding training is delivered in MFT. The new mandatory level 3 'Think Family' safeguarding training includes a Complex Safeguarding module. In 2022-23, **273** MFT practitioners attended bespoke complex safeguarding training.

[42] Safe Lives

		• The Senior Specialist Complex Safeguarding Nurse (SSCSN) has supported in the delivery of multi-agency training in Trafford including awareness raising sessions directly with young people. • The MSP complex safeguarding week of action around child exploitation was used as an opportunity for MFT safeguarding nurses and partners from the Complex Safeguarding hub, to visit each Emergency Department and Paediatric Emergency Department and 9 children's wards, speaking to around **80** members of staff, to raise awareness of exploitation and promote the use of the child exploitation risk indicator checklist. • MFT is represented at the Manchester and Trafford strategic and operational complex safeguarding groups including the Human Trafficking Partnership and the Challenger/Serious and Organised Crime Steering Group.
Embedding Safeguarding Arrangements	**MSP**	**MFT ensures representation at all the safeguarding subgroups of the TSSP and has clear reporting arrangements to the Group Safeguarding Committee and thematic Safeguarding Subgroups.** • The safeguarding team has reviewed membership and reporting arrangements to/from the Trust to TSSP to ensure that MFT is represented at all TSSP meetings with a clear reporting to frontline services for Trafford citizens • MFT have completed the annual Section 11 audit and Adult Assurance for MSP and Greater Manchester Contractual Standards NHS Provider Safeguarding and Looked After Children Tool Audit Tool and this has been submitted to the Integrated Care Board. • MFT are completing the annual Regulation 13 Safeguarding Assurance meetings in hospitals, MCS and LCO. • The MFT Process for embedding learning from child, adult or domestic homicide reviews has been shared with the wider partners at the MSP Learning and Improvement meeting as an example of good practice.

Manchester Advice and Guidance Service

5.3 Manchester has three multi-agency locality-based hubs called Advice and Guidance Service (AGS), which are in the north, central and south areas of the city. A specialist health visitor (HV) supported by a safeguarding administrator is based in the AGS and supports the multi-agency functions of the children's services front door process by gathering and sharing health information, which contributes to assessing the level of risk to children. The HV is based in the central hub with virtual support offered to the north and south hubs. A Named Nurse from the MFT safeguarding service provides management, professional support and leadership to the HV in the AGS as well as supporting the development of policies, procedures and guidance to ensure the role of health services is understood in the hubs. The Named Nurse also maintains a strategic link between the management teams in AGS and the wider health economy, supporting the management of difficult cases or complex decision making, whilst ensuring the escalation process is fully understood and utilised when required.

5.4 There were **1,960** (1,915 in 2021-22) referrals into the AGS HV regarding children and young people, which required health information to support the identification of risks to these children. In total **2,973** (3,070) MFT health checks were completed on the referrals, which included system checks and telephone calls with community health, primary care professionals and health colleagues in the acute hospitals. The total enquiries for each area were:

- North **586** (590)
- Central **737** (698)
- South **418** (432)

5.5 In addition, data is collected for other enquiries including, **219** Channel and Early Help enquiries**.** In quarter 4, there were **116** health professional contacts to the AGS HV for case updates and outcomes on cases.

5.6 The AGS HV completes dip samples of referrals from health practitioners to ensure that they are using the correct referral process of having a meaningful telephone conversation with a social worker rather than submitting a written referral. In the retrospective Q1 audit there was still evidence that some referrals were still being sent in writing, mostly from the acute hospitals. Following the dip sample, the AGS practitioner has visited the acute hospitals and has worked with the safeguarding teams to improve the referral process and raise the profile of the AGS health practitioner role.

5.7 Since Q2 the AGS health practitioner has been involved in the AGS monthly multi-agency audit meetings. Referrals into AGS are randomly selected from across the three locality AGS hubs. The purpose of the audits is for managers and partners to review and discuss cases and explore what is working well and consider practice improvements. In Q2 the focus was on health referrals and the appropriateness of the referrals into AGS. Learning from the audit was that two of the referrals could have been signposted to Early Help and one of the actions was for the AGS teams to have the knowledge and skills to utilise the support of Early Help, including them as part of the step-down plans for families.

5.8 In Q3 the focus of the audit was GP referrals and this was useful for the community safeguarding team to understand the issues as they provide the advice and guidance to GPs. In Q4 the focus of the audit was on referrals from education. The key messages from the audits are shared quarterly in the MFT Safeguarding Newsletter and through the Quality and Learning Subgroup with a plan of what needs to happen to improve practice where necessary.

5.9 The AGS health practitioner coordinates health information for the Channel [43] Meetings, part of the Prevent strategy and now attends the Channel panel meetings as the health information representative.

[43] Channel is an early intervention scheme which supports people who are at risk of radicalisation aiming to help people to make positive choices about their lives and providing practical support tailored to individual needs.

Manchester Complex Safeguarding

5.10 A senior specialist nurse for child sexual exploitation (SSN CSE) is based within the Manchester multi-agency Complex Safeguarding Hub to provide specialist health advice and to act as the conduit for information sharing between health colleagues and the multi-agency teams to inform multi-agency risk assessments. This specialist nurse also offers an advice and consultation service to health professionals in respect of CSE as well as providing supervision, training and briefing sessions for MFT and multi-agency staff. The SSN CSE has a clinical caseload of young people who are 16-18 years old, hard to reach and do not have access to a school nurse for support.

5.11 A total of **211** (217 in 2021-22) referrals were made to the Manchester Complex Safeguarding Hub. The breakdown included child sexual exploitation (CSE) **49** (61), child criminal exploitation (CCE) **112** (138) both CSE and CCE **27** (18) and serious youth violence (SYV) **23**. This SYV data has only recently been collected separately from CCE.

5.12 The CSE Senior Specialist Nurse provided health information on **213** (217) children and young people in the daily briefing meetings which is where referrals are discussed. Updates have been provided to lead health professionals on **864** (871) cases, the GP has been informed of referrals and closures in **247** (325) cases that were open to the Complex Safeguarding Hub.

5.13 For the first time in 2022 the Greater Manchester (GM) peer review of the health input into the Manchester Complex Safeguarding Hub was audited externally, which ensured an objective review of cases. The peer review was conducted by the GM Complex Safeguarding Hub Review Team alongside a team of multi-agency peer-reviewers from Tameside Complex Safeguarding Team. Highlights from the review gave positive comments on:

- The “flexibility and tenacity of approach” with children and young people by the CSE Senior Specialist Nurse, school nurses and Looked After Children nurses both in relation to their own work and joint work with multi-disciplinary colleagues.
- The clear evidence of considered and robust information governance in relation to the electronic patient record.
- The clear evidence of a timely response to pressing health needs and onward referrals and clear evidence of trauma informed practice guiding the CSE Specialist Nurse’s work with young people as well as in her support of health colleagues working directly with the child.
- Clear evidence of a ‘Think Family’ approach being embedded by health and the wider complex safeguarding team.

5.14 The CSE Senior Specialist Nurse is involved in monthly multi-agency reviews of cases open to the Complex Safeguarding Hub. The results are fed back to the school nurse heads of service for their oversight.

5.15 During the Greater Manchester exploitation week of action in October 2022, the Manchester Senior CSE Specialist Nurse, along with multi-agency colleagues from the Complex Safeguarding Hub, visited Emergency Departments and other departments across the Trust to raise awareness of exploitation and promote the risk indicator checklist (RIC). During the exploitation week of action in March 2023 the focus was on education. The CSE Specialist Nurse, supported by the Healthy Schools Team, developed a lesson plan for year 6 children around criminal exploitation. This was rolled out to 6 primary schools reaching **367** children in 13 classes and was positively evaluated by teachers. The CSE Specialist Nurse delivered a session to the special needs school nurses alongside a police colleague which was very well received and supported sessions with the North Education cluster meeting and the Manchester Schools Designated Safeguarding Lead training.

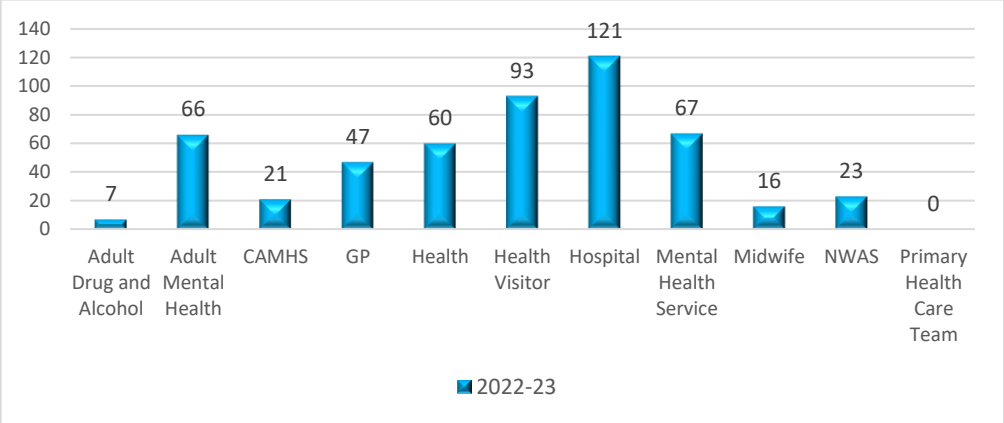
Manchester Adult Multi-agency Safeguarding Hub (MASH)

5.16 The Adult MASH is located centrally in the city. The provision of services to Adult MASH is led by Integrated Care Board. The MFT safeguarding team has continued to work closely with the MASH throughout this annual report year to ensure appropriate information sharing processes and good working relationships are in place.

Trafford First Response

5.17 The Specialist Health Practitioner who works within Trafford Children's First Response Team (TCFRT), the Front Door of Children's Social Care, supports the multi-agency team by gathering and sharing health information which contributes to assessing the level of risk to children. The health practitioner searches for, shares and collates health information from a wide range of NHS providers interpreting and sharing information that is necessary and proportionate to safeguard and/or promote the welfare of a child, whilst providing liaison between the first response team and community health, primary care and acute hospitals. During 2022-23 there was a total of **9147** referrals to the team with **1,447** identified as health referrals.

Figure 13: Health referrals to Trafford First Response Team.



5.18 From the figures above, the three highest health referrals in to TCFRT are from the Acute Hospitals, Health Visiting service and Mental Health Services.

5.19 The specialist health practitioner continues to dip sample health referrals to TCFRT to review if the correct referral process is used, that referrals are being submitted at the appropriate level of need and that feedback is provided to the referrer.

5.20 Multi-agency working and Information sharing continues to work well within TCFRT, with evidence of excellent inter-agency working. The informative and prompt information that is shared enables the right support for the families to be given at the right time The health role is being continually developed with a plan for the specialist health practitioner to be more involved with screening the referrals received going forwards.. Areas for development for 2022-23 include collecting the data and reporting on the number of health practitioner contributions to safeguarding referrals that TCFRT receive.

Trafford Complex Safeguarding Team SHINE

5.21 Throughout 2022-23 the Senior Specialist Complex Nurse (SSCSN) has continued to embed her role within the Trafford Complex Safeguarding Team SHINE. The role provides expert health advice and support to stakeholders working with children who are being exploited; and involves the attendance at complex safeguarding meetings to address any issues/concerns regarding CSE/CCE and missing from home (MFH).

5.22 The SSCN continues to hold a split role of three days per week with the Complex Safeguarding Team and two days per week as the Youth Justice Nurse. This role includes undertaking healthcare assessments to specific groups of children/young people, including the review of previously un-met health needs and a review of any assessments or referrals that have been made in earlier years, particularly where there is an Education and Health Care Plan (EHCP) or identified special education needs and/or disability (SEND).

5.23 The SSCSN has supported the TSSP Exploitation week of action to raise awareness around Complex Safeguarding within the borough. The SSCSN delivered a complex safeguarding presentation to the Designated Safeguarding Leads in Education and has supported delivery of multiagency complex safeguarding awareness raising sessions at a local youth club within the Trafford Borough.

5.24 The Greater Manchester Complex Safeguarding Peer Review was completed in Quarter 4 2022-2023 and highlighted from a health perspective:

- Evidence of embedding learning/practice from other area Complex Safeguarding Peer reviews.
- Clear evidence of trauma-informed work; particularly around understanding the journey of Unaccompanied Asylum Seeking Child and a cared for child.
- Evidence of good safety planning.

Figure 14: Categories of Cases Open to Trafford Complex Safeguarding Team SHINE

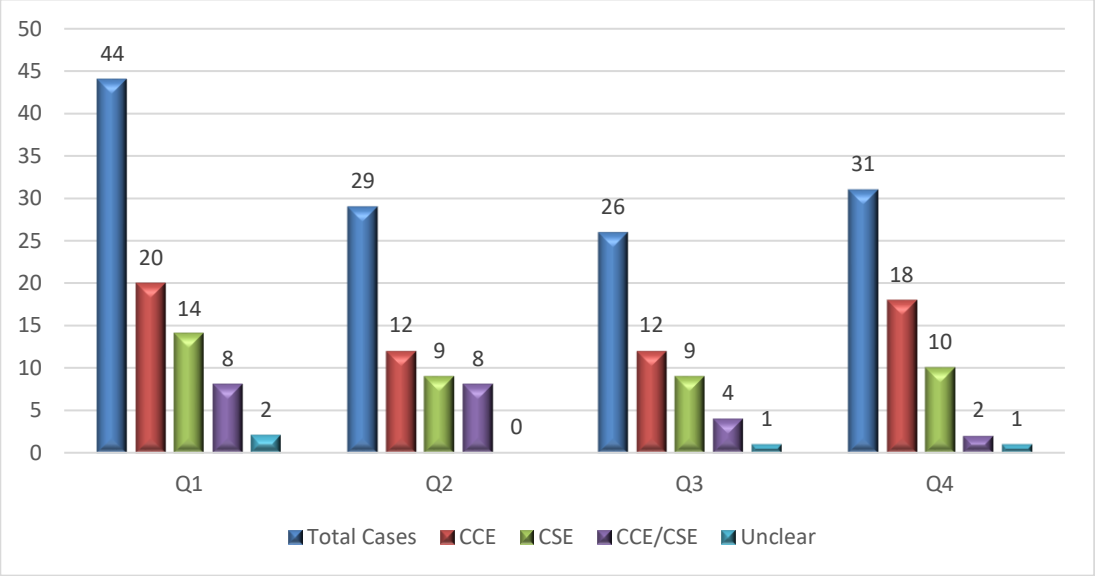


Figure **14** above shows that the greatest proportion of young people open to SHINE are experiencing Criminal Exploitation.

5.25 The SSCSN provides health representation at safeguarding meetings and children in care reviews for a defined caseload and delivers health interventions that improve the health and wellbeing of children who are being sexually and/or criminally exploited; to reduce gaps in service delivery by using knowledge of health systems/service and pathways. The SSCSN had **58** contacts with children and young people and attended **405** risk management meetings to support the health contribution of multi agency safeguarding plans.

5.26 Analysis has been completed of the health needs of young people open to Shine and identified that;

- 65.7% of young people open to SHINE at the end of Q4 were identified to have emotional and mental health needs including anxiety and self-harm. All were open to appropriate mental health services.
- 74.28% of the young people open to SHINE were identified to have substance misuse as a health issue.
- 11.42% of the young people open to SHINE were identified as having an identified sexual health issue.
- 20% of the young people opened to SHINE were identified as having a physical health concern.

Serious Case Reviews (SCR)/Child Safeguarding Practice Reviews (CSPR), Safeguarding Adult Reviews (SAR), Domestic Homicide Reviews (DHR)

5.27 CSPR, SARs and DHRs are commissioned through the multi-agency partnership arrangements in accordance with the statutory guidance[44] following the death or serious harm of a person through abuse, neglect or domestic homicide and where there is concern that agencies have not worked together to protect the victim. The purpose of the review is to learn lessons to improve multi-agency practice to safeguard children, young people and adults at risk and their families.

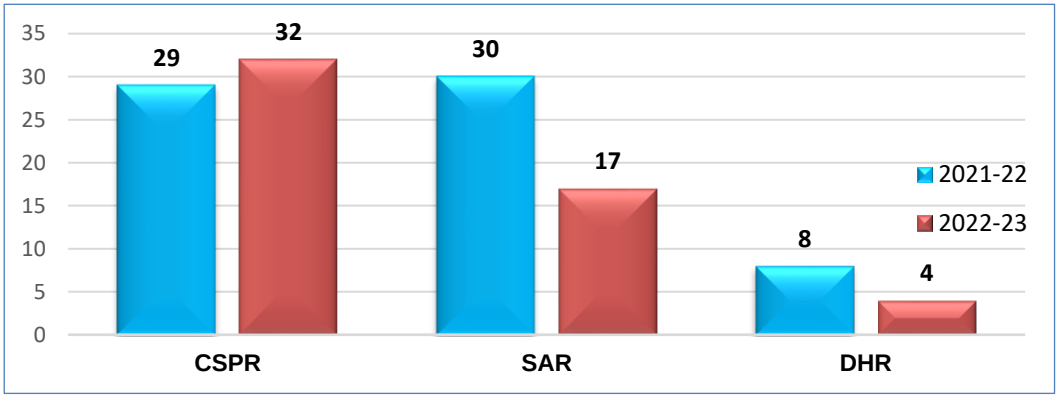
[44] Working Together to Safeguard Children

5.28 In June 2019, implementation of the 'new Working Together to Safeguard Children' (2018) statutory guidance determined that all new child reviews should be known as child safeguarding practice reviews (CSPR). This year has, seen the continued completion of the legacy SCRs as well as new CSPRs completion.

5.29 Prior to the decision to conduct a CSPR/SAR/DHR agencies are required to undertake a scoping exercise to provide initial information about the case.

Figure 15 below. Identifies the numbers of requests for scoping for CSPR/SAR/DHR this annual report year.

Figure 15: Scoping for CSPR/SAR/DHR, compared with 2021-2022



5.30 In 2020-21 there was a notable increase in activity for scopings, this increase has not continued with numbers of requests stabilising or decreasing in 2022-23.

5.31 The key themes and concerns from the child safeguarding scoping requests have been vulnerability of babies to physical abuse and neglect (**8** cases), young people involved in serious violence in the community including knife crime (**15** cases), children who were victims of child sexual abuse where there was multi agency working but delayed identification of risk (**6** cases), fabricated and induced illness in (**2** cases) and (**1** case) of physical injury in a child.

5.32 Key themes in adult scoping reviews are frontline services knowledge and skills in the recognition and response to concerns around neglect and self-neglect (**11** cases) and the response to safeguarding concerns in the context of mental illness, suicide and domestic abuse (**8** cases) where there has been ongoing multi-agency working with people with vulnerabilities, and complex safeguarding concerns, including the importance of reasonable adjustments for people with a learning disability(**1** case).

5.33 The significant learning themes, that have been shared through safeguarding governance groups, training, supervision and the safeguarding newsletter from the scopings, are;

- The importance of professional curiosity and "Think Safeguarding" when non mobile babies present with physical injuries due to their increased vulnerability to abuse and neglect.
- The requirement to foster an environment where safeguarding professionals are professionally curious to safeguarding concerns.

- The need to increase the workforce's knowledge and skills in recognition, response and multi-agency safeguarding to indicators of child sexual abuse, child neglect and self neglect in adults
- The importance of consistent application of MFT Safeguarding Policies (including the use of the Child Protection Information Sharing process) to safeguard vulnerable people.

5.34 Requests for scoping have predominantly been received from Manchester and Trafford Safeguarding Partnerships, however, there has been a significant number of requests from Bury, Oldham, Stockport and Rochdale Safeguarding Partnerships reflecting the communities use of services at MFT, in addition due to tertiary service provision MFT have contributed to reviews from Bristol and Nottingham Safeguarding Partnerships.

5.35 Currently the MFT Safeguarding Service are working with the Safeguarding Partnerships in Manchester, Trafford, Salford, Rochdale and Bury with ongoing reviews as well as new and emerging concerns.

5.36 Senior safeguarding nurses from across the safeguarding teams represent MFT on the review panels, they ensure that contributions to the review are provided from the hospitals/MCS/LCO management team and frontline services and ensure that key messages and lessons learned from the reviews are shared across the Trust through safeguarding training, the safeguarding newsletter, briefings presented to the safeguarding governance groups and specific hospital/MCS/LCO action plans.

5.37 For each serious case review, a Trust action plan is developed to ensure the learning is embedded in the organisation. The themes from the reviews are collated through the Quality and Learning Subgroup and learning is then cascaded to hospital/MCS/LCO safeguarding committees. In 2023-24 a revised process will be implemented to ensure learning identified at early stages of the review process, will be immediately be shared and action plans developed with hospital/MCS/LCO safeguarding committees monitoring delivery of action plans to enable learning to be implemented promptly and not waiting until publication of the review which may be several years after the incident.

5.38 This year MSP published[45] **1** SCR/CSPR and **1** SAR, TSSP published[46] **2** CSPRs, MSP and TSSP published a joint thematic CSPR N B and YK and Child S and Wigan Safeguarding Partnership completed **1** SAR. Manchester Community Safeguarding Partnership published[47] **2** DHRs. In addition, MFT completed a number of local learning reviews with safeguarding partnerships where threshold was not met for a CSPR or SAR.

5.39 Key messages from published reviews this year include the

- Safeguarding should use a "Think Family" approach

[45] Manchester Safeguarding Partnership Safeguarding Adult Reviews
Manchester Safeguarding Partnership Child Case Reviews
[46] Trafford Strategic Safeguarding Partnership Learning into practice
[47] Manchester Community Safety Partnership (MHSP) DHR Storm
[47] MHSP DHR Louise

- The requirement for MFT to implement the new revised MSP Self .Neglect and Hoarding Guidance (implemented through Early Help and Neglect group).
- Ongoing work to increase the frontline workforce knowledge and skills in application of Mental Capacity Act.
- The importance of enabling the workforce to respond to “critical moments” to effectively safeguard vulnerable people.

SECTION F

Safeguarding Activity and Performance

6. MFT Safeguarding Activity and Performance from 1st April 2022 to 31st March 2023

Introduction

6.1 This section of the report provides an overview of MFT safeguarding activity and performance from 1st April 2022 to 31st March 2023. It provides assurance that MFT has fulfilled its statutory and regulatory requirements for safeguarding children and adults as outlined in the Children Act 1989 and 2004, the Care Act 2014 and CQC Regulation 13.

6.2 MFT Safeguarding Services are comprised of the following teams:

- Acute Child Safeguarding
- Acute Adult Safeguarding
- Maternity Safeguarding
- Manchester and Trafford Community Safeguarding Children Teams
- Manchester and Trafford Looked after Children Teams
- Safeguarding Mental Health and Learning Disabilities and/or Autism Team

6.3 The safeguarding services are based on the Oxford Road Campus (ORC), Wythenshawe Hospital, North Manchester General Hospital (NMGH), and in the community at Rusholme Health Centre and Trafford Town Hall. Although they are centrally based, the teams work throughout the hospitals/MCS/LCOs aiming to be visible and accessible to all Trust services.

6.4 There has been good progress this year in ensuring consistent ways of working across the safeguarding service and incorporating a whole family approach to safeguarding. The introduction of the new electronic patient record through Hive across the Trust has strengthened consistency in the safeguarding response and documentation across the acute hospital sites.

Safeguarding Referrals for Adults and Children

6.5 Safeguarding referrals/notifications relate to cases that have been notified to the safeguarding teams and for which the teams have provided advice and case management support to MFT practitioners. A small proportion of these cases will be referred to the Local Authority (LA) child or adult services. The role of the MFT safeguarding team is to support practitioners in their decision making to ensure that each referral to child or adult protection services is at the correct threshold for statutory intervention.

6.6 **Figure 16** (below) provides a breakdown of referrals across the safeguarding teams for this report period.

Figure 16: MFT safeguarding referrals to each safeguarding team, 2022-23

MFT Safeguarding Team	Oxford Road Campus	Wythenshawe, Trafford, Withington, and Altrincham	NMGH	TOTAL	Top Three Categories of Referral
Children's Acute Safeguarding	**3285**	**1437**	**2929**	**7651**	• Child and Young Person mental health including self-harm • Neglect • Domestic Abuse
Adult Safeguarding team	**1974**	**1774**	**1080**	**4828**	• Neglect • Domestic Abuse • Sexual Abuse
Maternity Team	**5352**	**1530**	**1973**	**8855**	• Mental Health • Neglect • Domestic Abuse
Manchester Children's Community Safeguarding	**7050**			**7050**	• Neglect • Mental Health • Domestic Abuse
Trafford Children's Community Safeguarding	**490**			**490**	• Domestic Abuse • Neglect • Mental Health
Safeguarding Mental Health Team	**3855**			**3855**	• Mental Health
Safeguarding Learning Disability Team	**2005**			**2005**	• Learning Disability
Combined Total				**34734**	

6.7 Collectively during this annual reporting period MFT safeguarding teams have dealt with **34,734** referrals for children and adults with varying levels of need who were at risk of, or there were concerns that they were suffering abuse and/or neglect or support was required to provide care with patients with a learning disability, autism or mental health difficulty. This is higher than last year when there were 30,690 referrals received. The acute safeguarding adults and children teams have identified an increase in referrals this year. The increase equates to **95** safeguarding concerns alerted every day in the Trust compared to 84 in 2021-22.

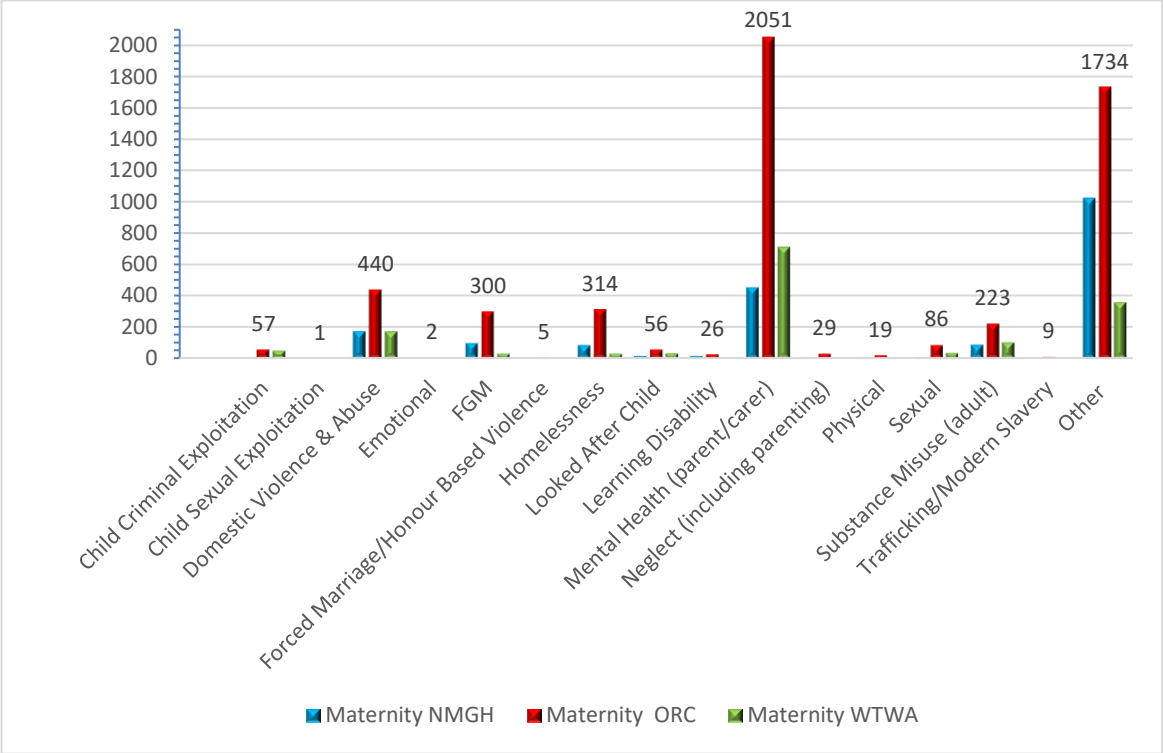
6.8 Safeguarding concerns relating to neglect in the care of adults and children, domestic abuse and the impact of mental health concerns on safeguarding are the most frequent categories of concern reported to the safeguarding team. This is consistent with the national data that identifies that neglect/omission of care and neglect in childhood is the most frequently reported safeguarding concern. Following the COVID-19 pandemic there has been an increase in safeguarding concerns relating to mental ill health.

Maternity Safeguarding Activity

6.9 Maternity safeguarding services are based at ORC, NMGH and Wythenshawe Hospital. The teams provide support to hospital and community-based services across MFT. The safeguarding maternity team continue to receive all referrals for vulnerable pregnant women, newly delivered women, new-born babies and their siblings.

6.10 **Figure 17** below shows the number of safeguarding referrals made to the Safeguarding Team at each site and the reason for the referral.

Figure 17: Maternity Safeguarding Referrals



6.11 Safeguarding midwives across all three sites continue to receive a high volume of referrals through the completion of the Maternity Information Sharing Form (MIRF). The total number of referrals has decreased this year to **8,855** referrals (10,499 in 2021/22). Consistent with previous annual reporting the most common category remains maternal mental health followed by domestic violence and abuse. This year the safeguarding assessment utisiled in the MIRF has been transferred onto Hive. There is ongoing work to optimise the use of Hive by St Mary's to report and document safeguarding concerns.

6.12 During 2022-23 there were **171** unborn babies made subject to a Child Protection Plan (CPP) at birth who were in receipt of MFT maternity services (NMGH – 40, ORC – 94, WTWA – 37

6.13 There were **95** babies removed from parental care through child care law proceedings following birth across the 3 sites, (50 from ORC, 24 from WTWA, 21 from NMGH), prior to being discharged from the maternity units.

6.14 In this period the Safeguarding Midwives at WTWA have supported with one case where an application was made to Court of Protection.

6.15 For all these babies a safeguarding care plan was recorded on Hive to ensure the professionals working with the child were updated and provided care in line with safeguarding need and risk.

6.16 The majority of safeguarding work is completed by the hospital midwives, specialist midwives and community midwives supported by the safeguarding midwifery teams who also provide additional support in very complex cases.

6.17 Across the MFT footprint all pregnant or postnatal women can be referred to an Independent Domestic Violence Advisor (IDVA) who works closely with the safeguarding team to risk assess victims/survivors of domestic abuse and formulate safety plans for victim/survivors, their unborn babies and families. This service is provided by the Midwifery and Domestic Abuse Support Service part of Manchester Women's Aid. The IDVA's have an honorary contract with MFT.

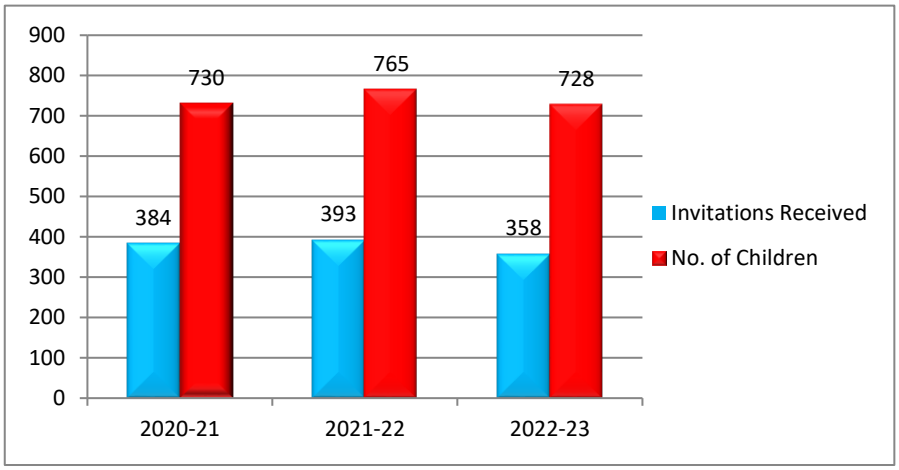
6.18 Maternity services at ORC identified **216** service users impacted by Female Genital Mutilation (FGM) with **(98)** identified at NMGH and (**30**) identified at Wythenshawe Hospital. The reporting demonstrates that routine enquiry about FGM at the maternity booking appointment remains well embedded. The number of women making FGM disclosures is reflective of the local population in Manchester and the increased vulnerabilities of women and girls living in FGM traditional practicing communities. Considerable work has been undertaken to raise awareness of the harmful impact of FGM to women and girls in Manchester. In recognition of this, St Mary's Hospital (SMH) hosts a 'New Steps' to African Communities psycho-social clinic to ensure service users are offered a holistic response to the identification of FGM.

MFT Contribution to Manchester Child Protection Plans (CPP)

6.19 When children are identified as being at risk of, or suffering significant harm from abuse and/or neglect health professionals contribute to the multi-agency child protection planning process. On 31st March 2023 Manchester LA, identified that **461**[48] (**503** 2022) children were subject to CPP in Manchester. This is a continued decrease from the **798** reported in 2020. **Figure 18** below shows the numbers of families where MFT health professionals were invited to attend Manchester child protection case conferences to ascertain if the child/ren were subject to, or at risk of, significant harm and required child protection planning. Manchester continues to have a decrease in children and young people subject to child protection planning in contrast to England where the number of children and young people subject to CPP plans is increasing.

[48] Data reported in MSP Children Safeguarding Children Quarterly Dataset reported to Safeguarding Effectiveness Committee'

Figure 18: Initial Child Protection Conference Invitations Manchester 2020-2023

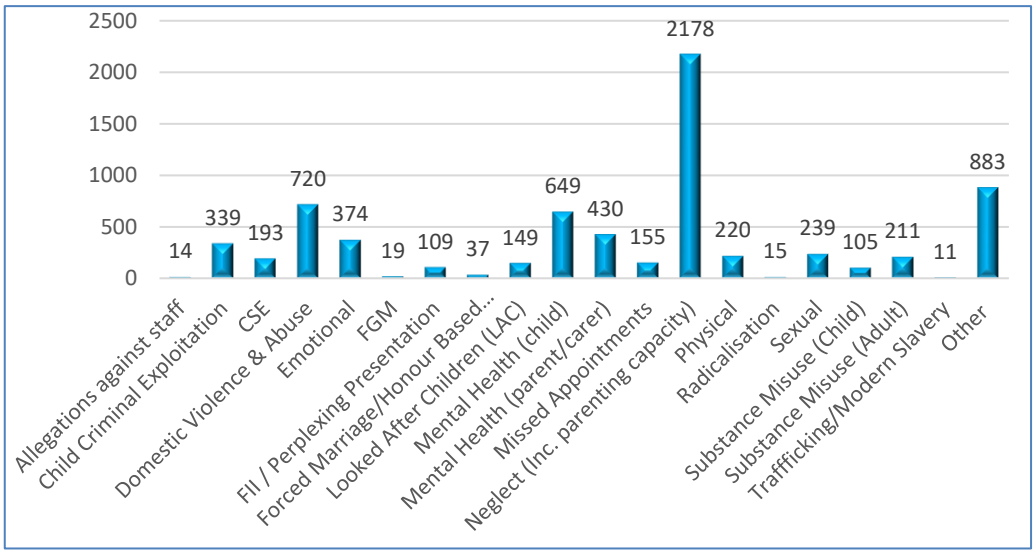


Manchester Community Children's Safeguarding Activity

6.20 The community safeguarding children team provide a citywide safeguarding service to all community staff working with children. Support for the community workforce is vitally important as health visitors and school nurses hold and manage high levels of complex child protection caseloads.

6.21 **Figure 19** below identifies the categories of concern notified to the community teams.

Figure 19: Community children's safeguarding notifications 2022-2023 by category



6.22 The Manchester picture aligns with the national messages that neglect is the most common cause of safeguarding concern for children and young people. Throughout this annual report year the community team have been supporting the implementation of the Manchester Child Neglect Strategy.[49]

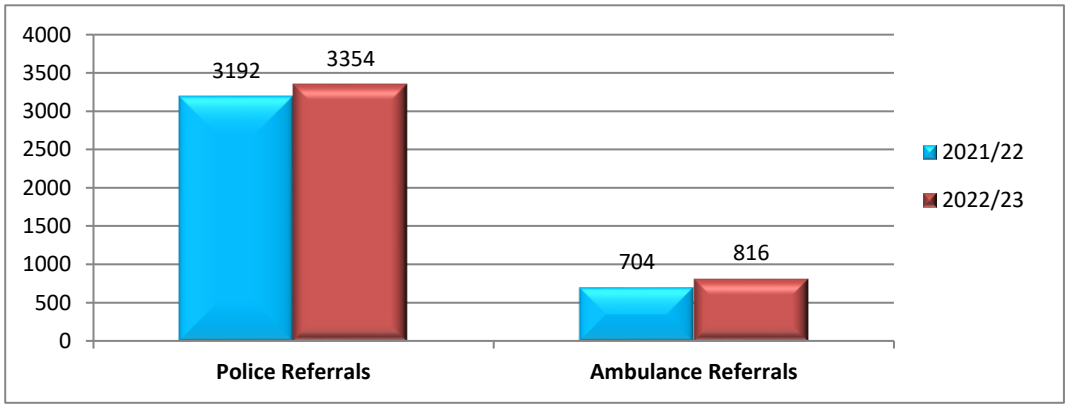
[49] Manchester Child Neglect Strategy (2021-2024)

Police and Ambulance Safeguarding Referrals

6.23 The citywide community safeguarding children team process safeguarding information sharing referrals from the police and ambulance services, ensuring that this information is disseminated to frontline health visitors and school nurses as appropriate. The referrals from the police are cases where there has been a Domestic Abuse Child Concern (DACC) meeting in the locality AGS and the information is shared to notify community health services, caseload holder (health visitor or school nurse) to review the incident to ensure the child or young person's health needs are being met and to assess if there are any additional vulnerability or risk factors for the child and family.

This also allows the health practitioner to build a chronology around a child's daily lived experience. In addition, for all preschool children there is an information sharing pathway between the police and health visitors facilitated by the child health department to inform of all domestic abuse incidents not reaching the DACC criteria to enable the delivery of 'Operation Encompass' in preschool children.[50]

Figure 20: Police and Ambulance Referrals to MFT Safeguarding Services



6.24 This year **3,354** police referrals were received from the AGS and shared with MFT community health staff an increase from the previous year.

Referrals from North Manchester General Hospital

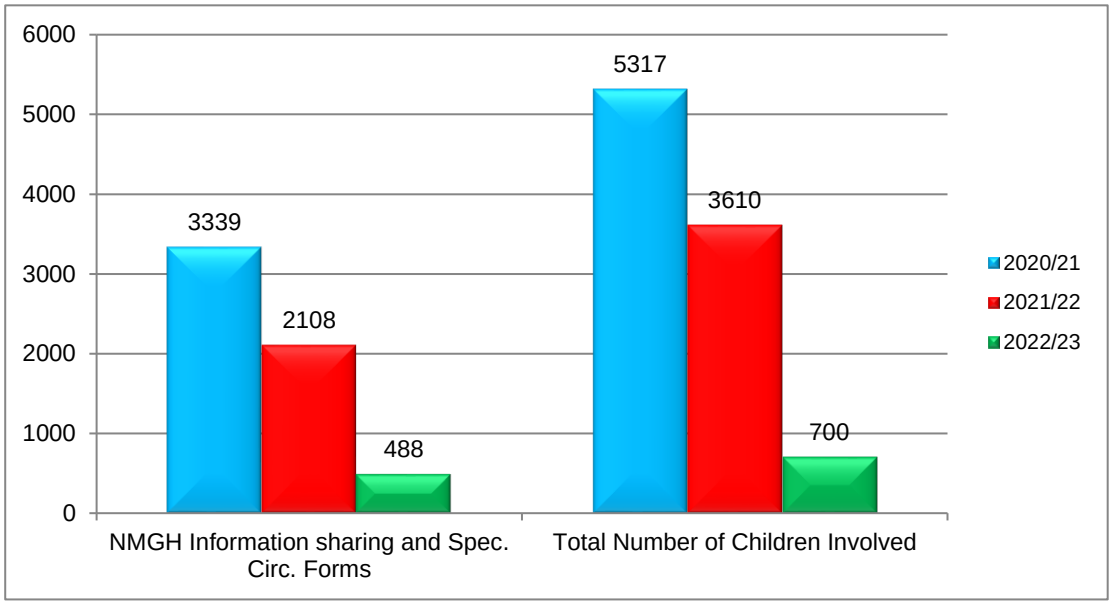
6.25 Lord Laming's recommendations following the Victoria Climbie inquiry in 2003[51] requires all emergency departments to notify the health visitor or school nurse when a child has attended. These notifications are well established across all Manchester hospitals and are shared by the MFT emergency departments directly with children's Community health services.

The information from NMGH was previously processed via the MFT community safeguarding team. The community safeguarding team ensured that these notifications were disseminated to the health visiting and school nursing teams, which are provided by MFT, for information and case management.

[50] Operation Encompass
[51] The Victoria Climbie Inquiry

Figure 21 below shows the number of notifications on the NMGH site over the past 3 years, year on year. In 2022-23 the information sharing from NMGH was streamlined by being sent directly to the community teams, hence the decrease in referral activity

Figure 21: North Manchester General Hospital Information sharing and Special Circumstances Forms 3-year comparison



Manchester Community Section 47 Child Protection Medicals

6.26 The community child protection clinic operates out of the Coral Suite at Moss Side Health Centre where a dedicated administration team (for Our Children and child protection medical assessments) is located. Referrals for paediatric assessment for children over 18 months old, with suspected physical abuse, are accepted. Any child under 18 months, or with injuries that are likely to need treatment, are directed promptly to hospital services. Referrals for suspected child sexual abuse are directed to The St Mary's Centre Sexual Assault Referral Centre. The clinic operates Monday, Tuesday, Thursday, and Friday 0830-1630 except for Bank and Public Holidays. Onward dental referrals and photographic documentation of injuries is provided on site. The service is compliant with RCPCH 2020 standards for section 47 medicals[52] and there are links to the community paediatric services for follow up.

6.27 In the year April 2022 to March 2023, there were **307** child protection medical assessments (section 47 medical assessments) undertaken within the community paediatric service (usually at the Coral Suite, although sometimes in schools). In addition there were **409 i**nitial health assessments of looked after children performed within the service. This is a total of 716 assessments undertaken over approximately 253 working days ie a mean of 2.83 children per day [3 children per day].

[52] https://www.rcpch.ac.uk/news-events/news/rcpch-publishes-uk-wide-child-protection-standards

Figure 22: Coral Suite (IHA and CP) Referral Chart

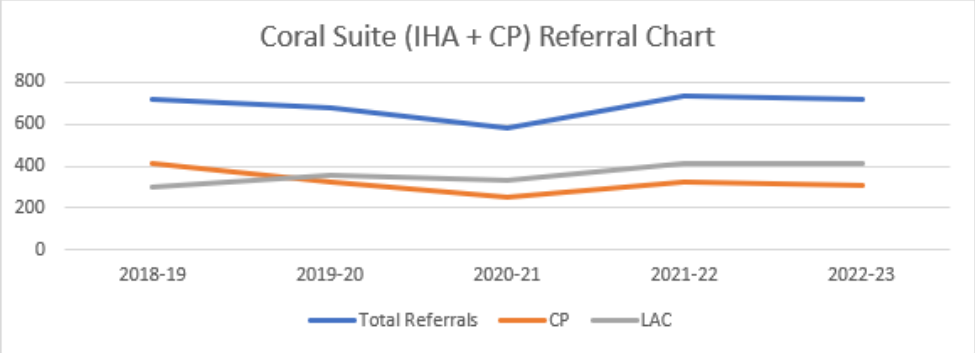
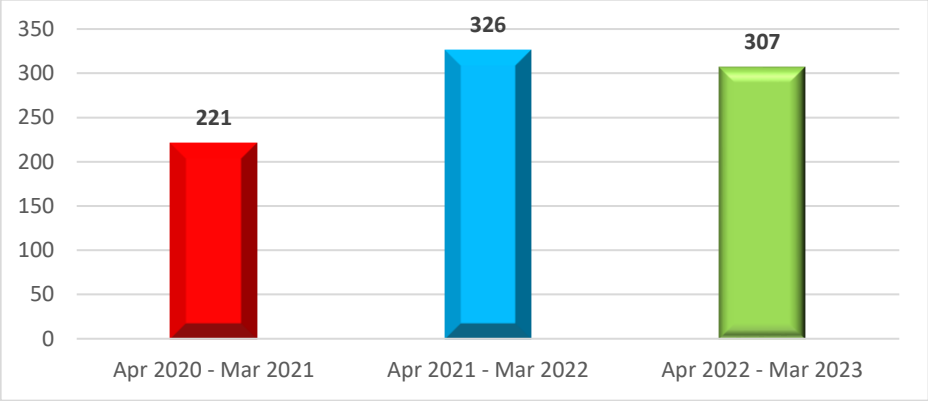


Figure 23: Number of Section 47 child protection medicals carried out from 2020/21 to 2022/23



Trafford Community Safeguarding Team

MFT Contribution to Trafford Child Protection Plans (CPP)

6.28 On 31st March 2023 Trafford LA identified that **223**[53] **(191** in 2022**)** children were subject to CPP in Trafford. The safeguarding team support the health professionals to safeguard these children and to effectively contribute to child protection planning. The number of children on CPPs in Trafford has increased similar to the increasing trajectory nationally.

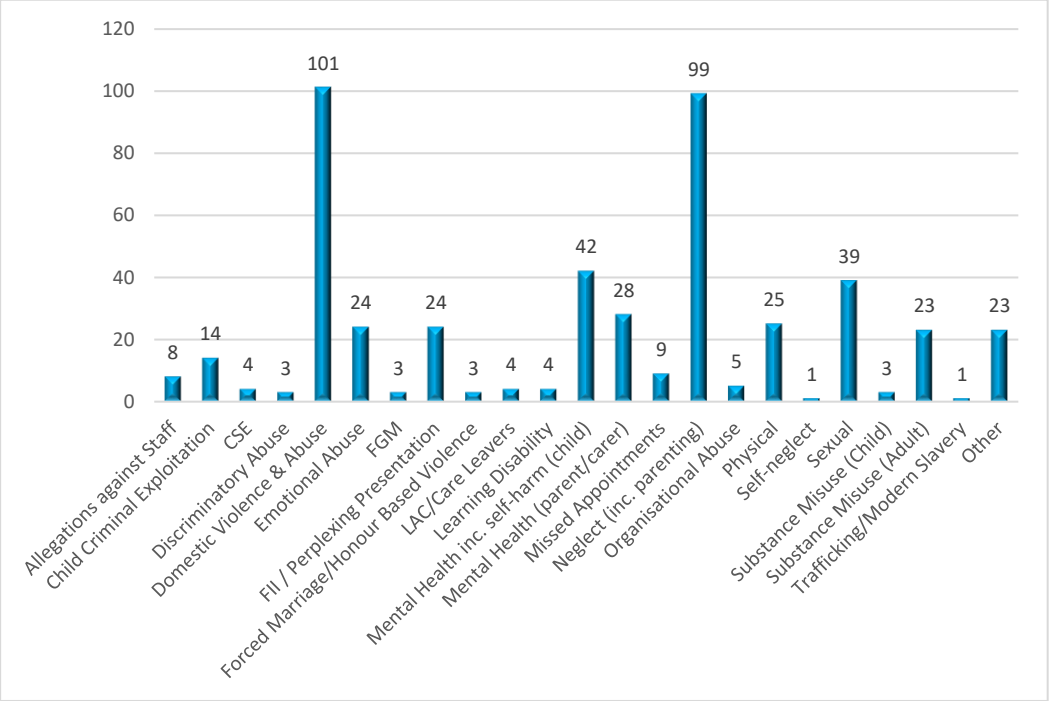
Trafford Community Safeguarding Children Activity

6.29 The Trafford community safeguarding children team provide a borough wide safeguarding service to all MFT community staff. **Figure 24** below reports the referrals to the Trafford team and identifies that this year domestic abuse and neglect are the most prevalent reasons for practitioners contacting the service for support and advice. Child mental health is another frequent concern for practitioners.

[53] Trafford Strategic Safeguarding Partnership Safeguarding Effectiveness Committee Children's Quarterly Dataset.

6.30 The Trafford team have worked with the TSSP to deliver neglect training as well as contributing to domestic abuse multi agency roundtable events. In addition, local domestic abuse training in the recognition and response to coercive control is being delivered to respond to the local priority safeguarding concerns.

Figure 24: Referrals to Trafford Community Safeguarding Team 2022-23



Police and Ambulance Safeguarding Referrals

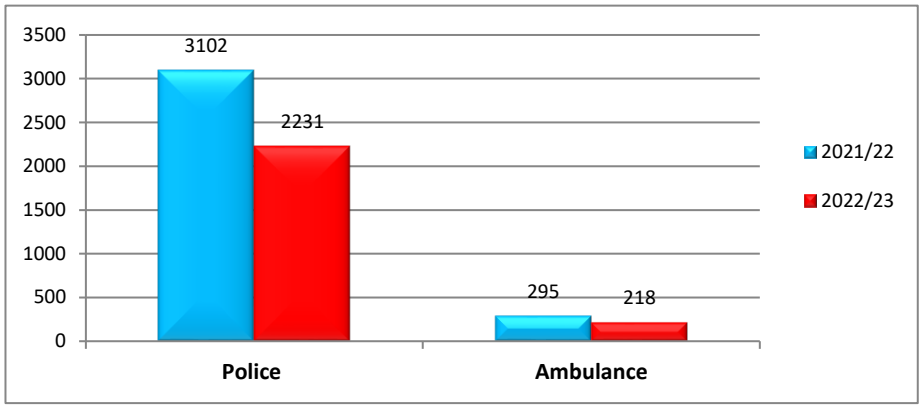
Police Referrals:

6.31 The community safeguarding children team process safeguarding referrals from police and ambulance services ensuring that this information is disseminated to frontline health visitors and school nurses. There were **2231** police child protection notifications received which is a decrease compared to the previous year (**3,102** 2021-2022). The referrals from the police relate to any police call outs regarding domestic violence and abuse; missing children; welfare concerns; youth knife crime. A daily risk management meeting is held which is multiagency and review the police call outs in the preceding 24 hours.

Ambulance Referrals:

6.32 The safeguarding team share information with the community health practitioners to inform their safeguarding risk assessments when referrals are shared from Northwest Ambulance Service. There were **218** referrals this year compared to the previous year 2021-2022 (**295**).

Figure 25: Police and Ambulance Referrals 2021/22 compared to 2022-2023



Trafford Community Section 47 Child Protection Medicals

6.33 The community child protection clinic operates out of Trafford General Hospital Children's Resource Centre. Referrals for paediatric assessment for children over 18 months old, with suspected physical abuse, are accepted via Trafford Borough Council Children's Social Care at the Child Protection Clinic. Any child under 18 months, or with injuries that are likely to need treatment, are directed promptly to hospital services. Referrals for suspected child sexual abuse are directed to the St Mary's Centre Sexual Assault Referral Centre.

6.34 In the year April 2022 to March 2023, there were **66** child protection medical assessments (section 47 medical assessments) undertaken within the community paediatric service following **99** referrals. Medicals that were referred but did not progress to a community medical were due young children being redirected to acute services, redirections to SARC or an agreement that the medical was no longer required following discussions with the social worker.

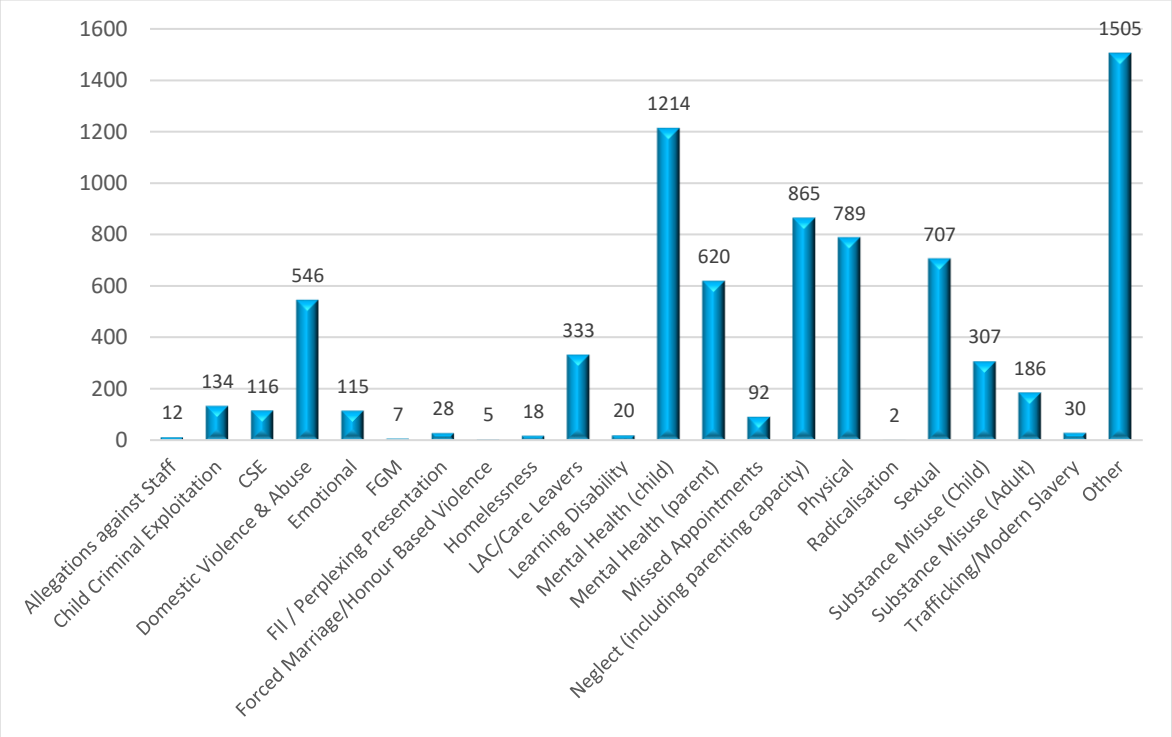
Children's Acute Safeguarding Activity

Children's Acute Referrals

6.35 The acute safeguarding children service is delivered from ORC, NMGH and Wythenshawe Hospital. The teams have continued to promote their availability and visibility across the service areas this annual report year.

6.36 **Figure 26** shows the number of referrals or alerts to the acute child safeguarding team in 2022-23 by category of abuse. The data shows an increase in the total number of referrals and alerts to the acute team this year from **6,531** in 2021-2022 to **7,651** in 2022-23. There has been a strengthening of safeguarding supervision this year throughout the children's acute footprint and it is hoped that this has also impacted on the frontline practitioner's recognition and response to safeguarding concerns.

Figure 26: Referrals to the Acute Safeguarding Children Teams



6.37 The reporting of safeguarding concerns this year continues to show high levels of child safeguarding concerns around adult and child mental health following the impact of the COVID-19 pandemic. In contrast to community/maternity services and the national data, the referrals with concerns around sexual abuse remain high, this is attributed to the service supporting Greater Manchester and Merseyside Sexual Assault Referral Centre (SARC). Referrals for physical abuse remain high reflecting the support the team provide to RMCH which is a tertiary hospital and a significant number of children and young people attend the hospital following serious safeguarding incidents following physical harm including knife crime or abusive head injuries. Referrals for child neglect have also increased following the national trends in reporting.

6.38 The acute safeguarding children team have supported the Greater Manchester Health and Social Care Partnership Children and Young People (CYP) in Crisis Escalation & Support Framework[54], which identifies that a CYP in crisis are those that are medically fit for discharge from acute hospital settings but remain in hospital until a tier 4 mental health admission or local authority residential placement is identified.

6.39 Analysis of data from October 2021 until February 2023 identify that there have been **20** children and young people in crisis aged between 11.5 years to 17 years with the majority having suffered significant trauma and or have complex needs such as neurodiversity or learning needs. The length of stay ranged from 9 days to 189 days.

[54] Greater Manchester Health and Social Care Partnership (2022) Children and Young People in Crisis Escalation & Support Framework local MFT Management of Children and Young People in Crisis who Require an Inpatient Admission as a Place of Safety

Section 47 Child Protection Medicals

6.40 Child protection medicals are provided by acute paediatricians to contribute to section 47 child protection enquiries in hospitals for children less than 18 months of age or where an acute or urgent out of hour's medical is required or when a child presents to hospital with injuries or other conditions where safeguarding concerns have been raised.

Oxford Road RMCH Section 47 Child Protection Medicals

6.41 The electronic database at RMCH has recorded **123** child protection assessments undertaken by the paediatric team. Most of these assessments have been a result of clinicians identifying potential safeguarding concerns relating to the child's presentation.

Wythenshawe/RMCH Child Protection Medicals

6.42 Wythenshawe Paediatric team continue to provide child protection/S47 medicals for South Manchester and Trafford Children's Social Care (CSC) for children aged less than 18 months of age and for older children when medicals are not available in the community clinics. However most of the assessments are for children seen acutely at the hospital where safeguarding concerns have been raised. **59** medicals were completed over the last year (an increase from 35 medicals last year), 17 of which were requested by CSC.

North Manchester/RMCH Child Protection Medicals

6.43 There were **39** child protection medicals completed at the NMGH site this annual report year.

Adult Acute Safeguarding Activity

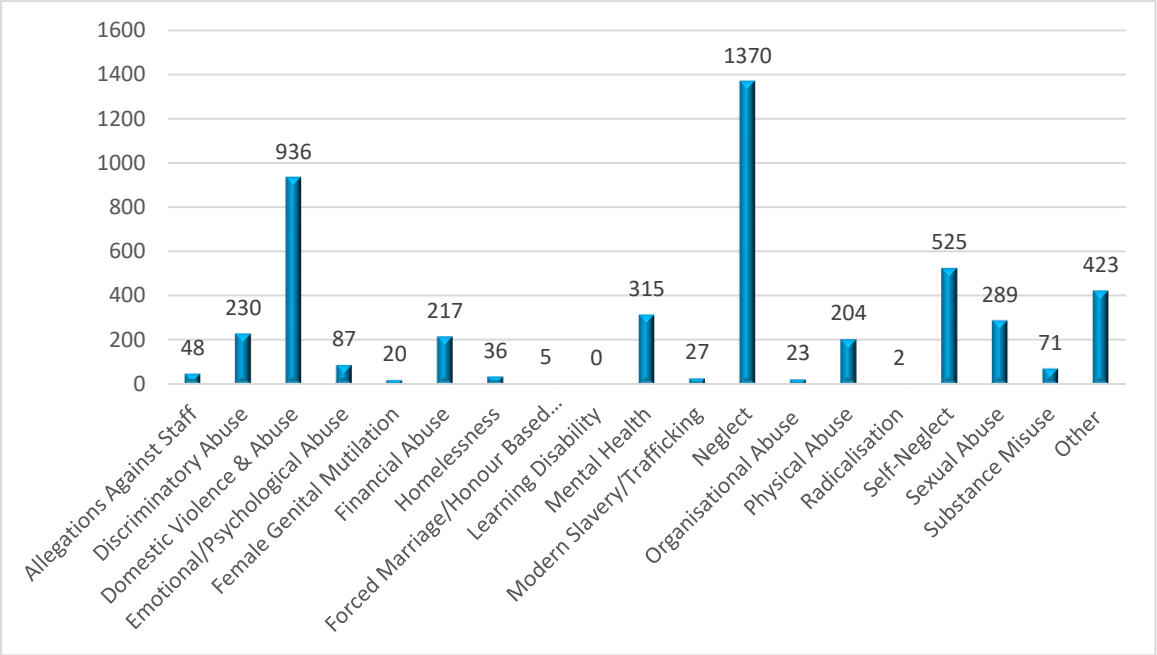
6.44 The safeguarding adult teams are based at ORC, NMGH, Wythenshawe and Trafford community locations to support MFT hospital and community services. The safeguarding mental health and learning disability specialist nurses are based within these teams and provide a service across the whole of the MFT footprint.

Acute Adult Referrals

6.45 The total number of referrals to the adult acute safeguarding teams in 2022-23 was **4828** to the adult safeguarding team, **3,885** to the mental health team and **2005** to the learning disability team compared to a total of **8,226** in 2021-2022.This demonstrates a continued year on year increase in reporting of safeguarding concerns or requests for support to meet the needs of patients with a learning disability, autism or mental health difficulty.

6.46 **Figure 27** shows the breakdown of referrals by category.

Figure 27: Referrals to the Adult Safeguarding Teams



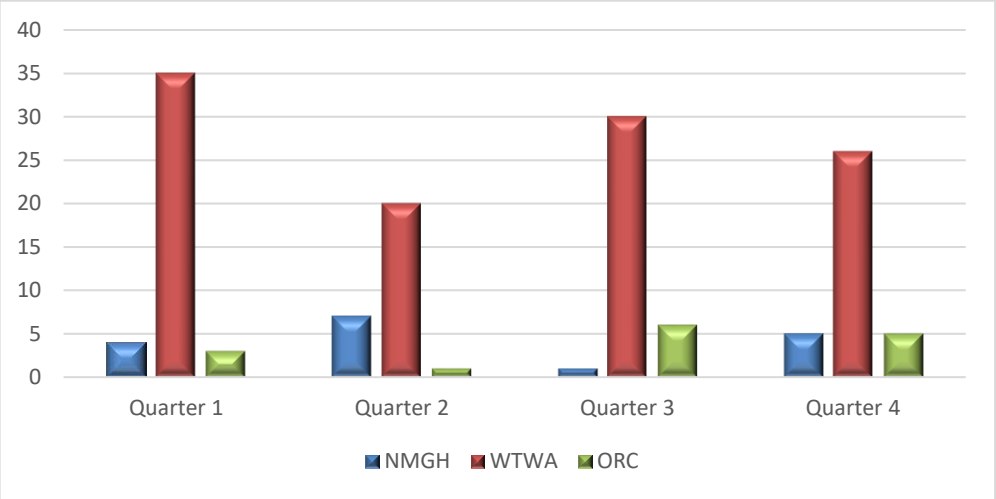
6.47 The key categories of concern identified by MFT staff in safeguarding referrals reflect the National, Manchester and Trafford picture (identified in Section B of this report); namely neglect/omission in care is the most frequently reported safeguarding concern. Domestic Violence and Abuse is the second most frequently reported category of concern which doesn't reflect national reporting but is in line with local Community Safety Partnership reporting of prevalence of domestic abuse in Manchester. The high referral/notification rate for sexual abuse at ORC relates to safeguarding support given to the SARC, which is a Greater Manchester and Merseyside service.

6.48 Figures for mental health and learning disability reflect the support from the safeguarding team to frontline practitioners in the care of our patients with a learning disability and/or autism or where there are mental health concerns. There has been an increase this year to **5,860** reports compared to **3,878** in 2021/22 reflecting increased capacity of the team, improved data collection and increasing requests for support.

Section 42 Adult Safeguarding Enquiries

The safeguarding and risk and governance team have supported the hospitals, managed clinical services and LCO to respond to **144** S42 enquiries (see **Figure 28** for a breakdown by site). The most frequent theme of the S42 enquiries was is unsafe discharge with concerns being identified in communication and handover of care especially around changes in medication.

Figure 28: Section 42 Adult Safeguarding Enquiries in 2022-23 by Site



Deprivation of Liberty Safeguards (DoLS) activity

6.49 MFT is a managing authority under DoLS legislation and is required to apply to the relevant LA (supervisory body) if it is identified that a patient who is deemed to not have mental capacity to consent to care and treatment is being deprived of their liberty. If a potential deprivation of liberty is identified, hospital/care home staff are required to complete the relevant documentation self-authorising the deprivation for 7 calendar days. This completed form is forwarded via secure email to the relevant LA where the patient is a usual resident.

6.50 Once processed by the LA, the LA is required to commission a Best Interest Assessor and a Mental Health Assessor who will complete the six assessments required to authorise a standard application. This assessment process should occur prior to the expiry date of the urgent authorisation. This year, **3,866** DoLS applications were made by MFT staff. This is a decrease from **4,303** reported last year.

6.51 There has been considerable activity through training, policy guidance and the use of the Hive and Ulysses informatics systems to promote, streamline and ensure DoLS are put into place appropriately. Point prevalence reviews have taken place and have identified that at NMGH and WTWA, there was a good understanding of recognition of patients who required a DoLS application. In MRI, the point prevalence identified limited assurance that patients who required a DoLS, had an application made identifying the requirement to focus training to the workforce is this area.

Figure 29: 2022-23 Deprivation of Liberty Applications and Outcomes

	ORC				NMGH				WTWA				Total
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	
Number of DoLS applications	190	226	264	259	369	346	386	369	412	383	327	335	**3866**
Number granted/authorised	3	0	2	5	2	0	2	2	0	1	9	3	**29**
Number waiting assessment	52	84	63	101	450	453	361	165	398	369	307	329	**3132**
Number RIP/discharged prior to assessment	132	141	143	156		154	20	196	0	5	4	0	**951**
Number withdrawn/regained capacity	3	1	0	2		9	5	6	0	8	5	2	**41**

6.52 **Figure 29** above provides data which identifies the Trust activity regarding DoLS and outlines the numbers of DoLS applications assessed and granted by the LA compared to those submitted. Of the **3,866** DoLS urgent authorisations/standard applications made only **29** were granted. Delays have continued in the processing and assessment of DoLS applications by Manchester and Trafford City Council. The number of DoLS authorised remains consistent with 2021-22 when from **4,303** applications made **26** were authorised. The delays and the associated low numbers of DoLS authorised have been recognised as an organisational risk and are recorded on the Trust risk register.

6.53 The safeguarding team has reviewed the internal application process for DoLS through audit and review as well as through external escalations pathway work with Manchester LA DoLS team to piortise completion of DoLS for patient's requiring more restrictive interventions. The Trust audit plan in 2023-24 will continue to review the application of the Mental Capacity Act in assessment and best interest care planning and the application of the DoLS process. Further work will also take place to utilise Hive more effectively in the DoLS process.

6.54 The challenges to the current DoLS process are recognised nationally and responded to in the Mental Capacity Amendment Act (MCA), which was granted Royal Assent in May 2019, and which introduces the new Liberty Protection Safeguards process (LPS). LPS aims to streamline the current process but will place an increased duty on acute settings for the authorisation of the deprivation. MFT contributed to the national consultation on the Code of Practice for LPS. However, in April 2023 it was announced that LPS would not be implemented in the lifespan of the current parliament[55]. Therefore next year the Trust will refocus on Mental Capacity Act and DoLS and "Getting it Right in Practice".

Domestic Violence and Abuse (DVA)

6.55 Domestic violence and abuse (DVA) training is in place across the Trust, with the aim of preparing staff to be able to recognise, respond and refer when DVA is a safeguarding concern. This year domestic violence and abuse training has been introduced as a mandatory training module in level 3 safeguarding training. In addition **229** staff have attended bespoke loicalised domestic violence and abuse training courses.

Multi-agency Risk Assessment Conference (MARAC) Activity

6.56 The safeguarding service continues to support the Trust contribution to MARAC, which is the process where all agencies including health staff identify and risk assess victims of domestic abuse referring the highest risk victims for a multi-agency risk assessment conference to facilitate safety planning in order to reduce the risk of harm and domestic violence homicide.

6.57 The Trust makes a significant contribution to the Manchester and Trafford MARAC. There were **2555** referrals to Manchester MARAC this year, which is a decrease from the **3407** in 2021-22.

[55] LPS delayed beyond the life of this Parliment

6.58 In Trafford there were **726** MARAC referrals, which is an decrease from **813** last year.

Female Genital Mutilation (FGM)

6.59 Mandatory reporting and the FGM Data Collection Tool

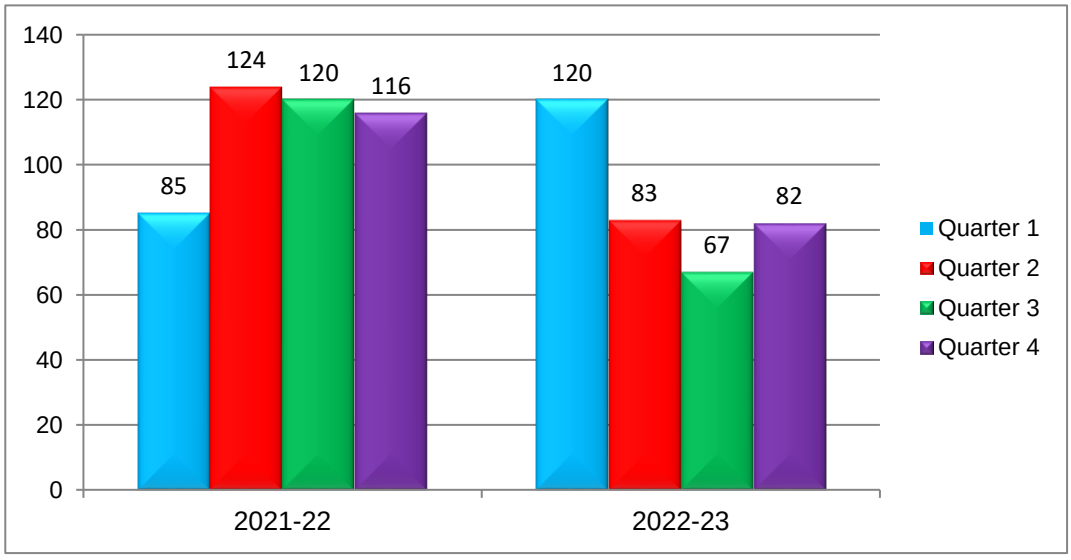
There are three information systems/situations where information about women and girls affected by FGM must be shared[56] by health professionals.

- FGM Information Sharing System (FGM IS). Information is uploaded at birth to a female child's health record if they are born to a mother who has had FGM. This information is used to support safeguarding girls throughout their childhood.
- FGM mandatory reporting to the police when a girl under 18 years old discloses or is observed to have had FGM. Safeguarding referrals to children's social care must also be completed.
- FGM enhanced data set is completed through the FGM reporting tool when a contact is made with a service user who has had FGM. This enables patient population statistics to be collected.

6.60 The mandatory reporting data identifies a significant decrease in the number of observations and disclosures from service users who have had FGM, with **352** reports this year compared to **445** in 2021/22. In comparison with the NHS national dataset[57] MFT continues to have one of the highest prevalence of FGM reporting in the country. The data reflects the local population demography of communities associated with a high risk of practising FGM as well as demonstrating an awareness of FGM across the Trust and a consistent and embedded approach to routine enquiry regarding FGM in health visiting and midwifery practice.

6.61 The MFT domestic violence and Abuse and FGM group continue to review the local data and monitor processes for recognition and response to FGM.

Figure 30: FGM Mandatory Reporting Data



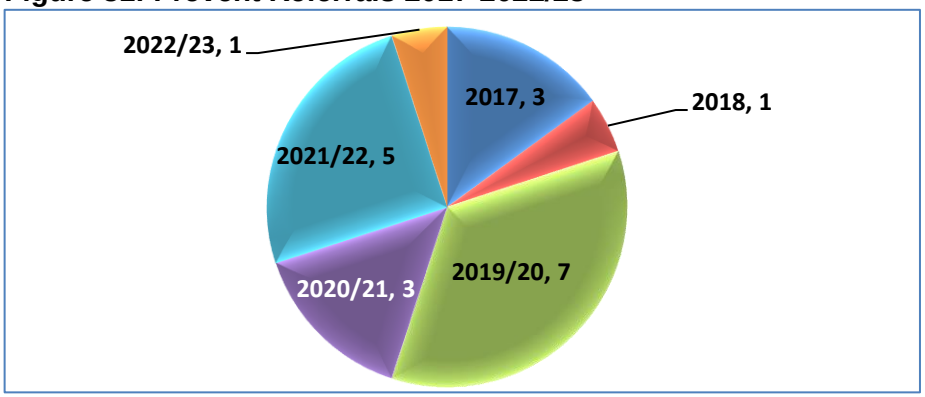
[56] FGM Risk Indication System
[57] Female Genital Mutilation national dataset

Prevent Activity

6.62 The safeguarding team provides advice and guidance where there are concerns around radicalisation. The team also manage referrals to the Channel programme, which focuses on providing support at an early stage to people who are identified as being vulnerable to being drawn into terrorism. In 2022-23 there were **28** information sharing requests completed for Channel and **1** Prevent referrals were made by MFT. The safeguarding teams represent MFT at the Manchester and Trafford Channel panels.

6.63 This data demonstrates that very few referrals are made to Channel by the Trust, despite mandatory training and raising of awareness at all levels. The data aligns with the GM Prevent data sets shared through local Prevent networks, which identifies the majority of Prevent referrals from health services are from mental health providers. Additional training on Prevent has been undertaken by the safeguarding team this year to raise awareness in the safeguarding team of Prevent to support safeguarding supervision, advice and consultation.

Figure 31: Prevent Referrals 2017-2022/23

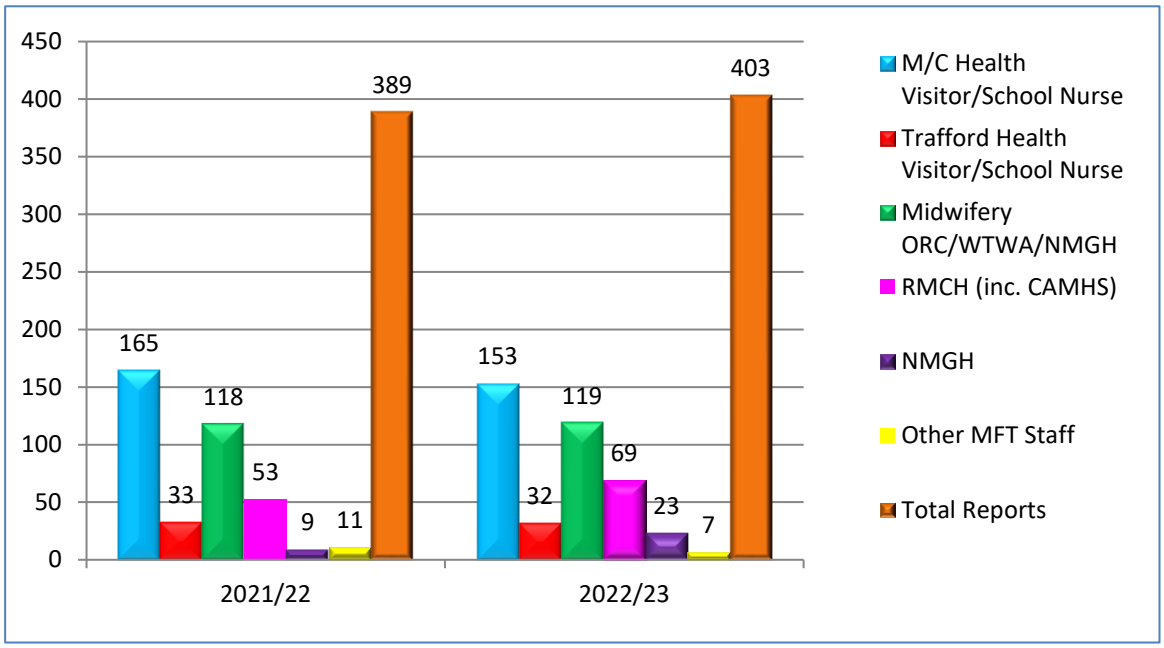


Court Report Activity for Child Care Public Law Proceedings

6.64 Court reports are requested mainly by Manchester City Council (MCC) and Trafford Metropolitan Borough Council legal teams and have to be completed by health practitioners within defined timescales. Robust quality assurance by the MFT safeguarding team prior to submission of the reports ensures that very few frontline practitioners are called to give evidence in court.

6.65 **Figure 32** below outlines the numbers of court reports quality assured by the safeguarding team in 2022-23 compared to 2021-22. Childcare proceedings are commenced when the multi-agency safeguarding concerns have reached the threshold for legal intervention.

Figure 32: Court reports quality assured by the Safeguarding Team



Safefguarding Supervision

6.66 Local and national learning highlights the importance of relevant staff receiving safeguarding supervision to support reflective and critical analysis in complex safeguarding cases. For this reason, safeguarding supervision is mandatory for all child services community staff who are caseload holders. This year safeguarding supervision has been delivered both virtually and face to face.

6.67 **Figure 33** below shows the high levels of compliance maintained this year for the delivery and attendance of safeguarding supervision within children's community services in Manchester. In Trafford the safeguarding team has worked with community services and the wider safeguarding team to strengthen the safeguarding supervision process. In 2022-23 the community safeguarding team in Trafford will continue to work with community health leads to promote improved and consistent compliance in safeguarding supervision.

Figure 33: Community Safeguarding Supervision Compliance 2022-23

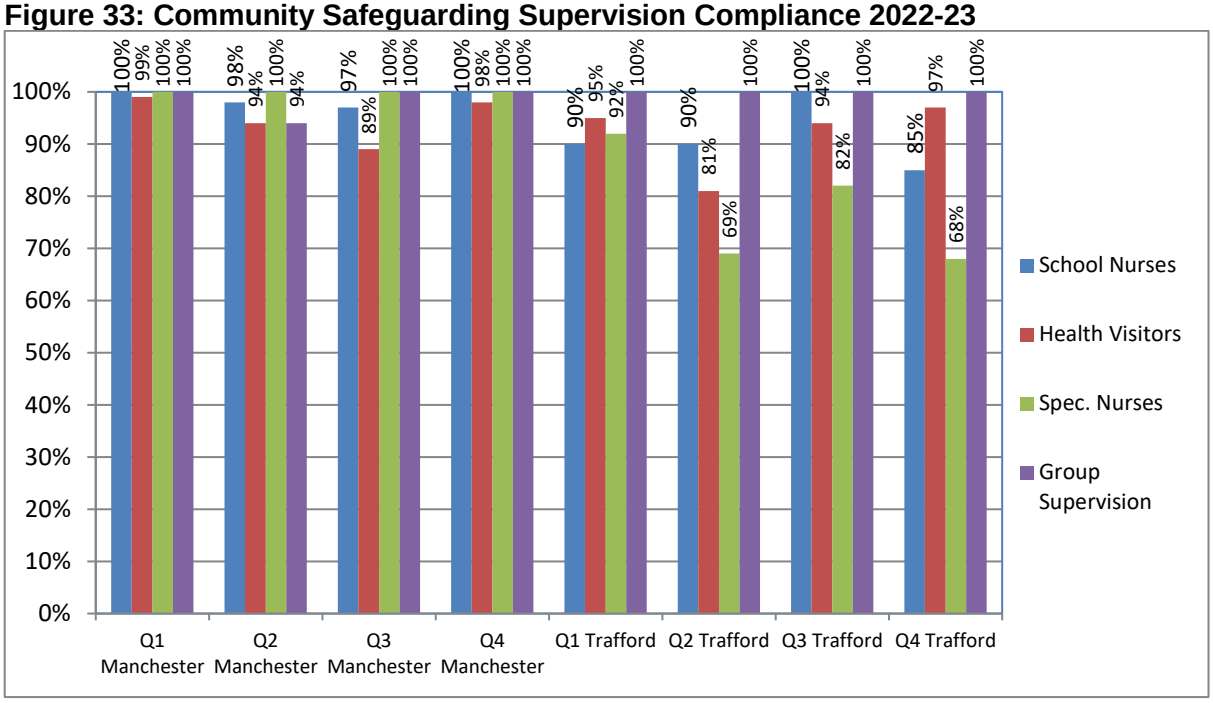


Figure 34: Total Number of Staff receiving Safeguarding Supervision across MFT 2022-23

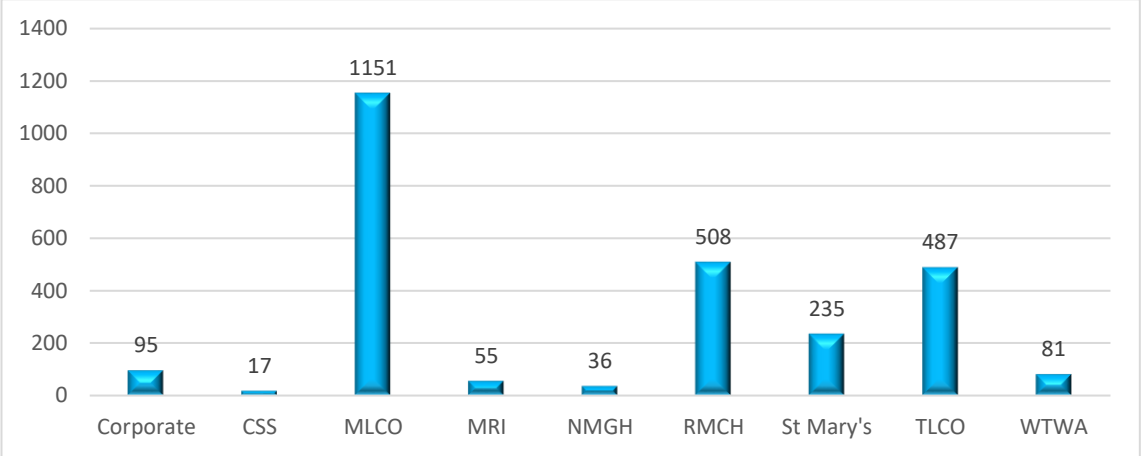


Figure 34 above shows the numbers of staff receiving safeguarding children supervision across the Trust (**2,479)**. As well as to LCO practitioners, supervision is delivered to the midwives in St Marys, to paediatric and CAMHS services in RMCH, to sexual health staff in MRI and to the corporate safeguarding team as per the statutory requirements.

This year has seen a strengthening in the supervision offer in RMCH, an introduction of adult and child "Think Family" safeguarding supervision and delivery of adult safeguarding supervision in the LCO. There is a requirement in 2023/24 to review data and recording of safeguarding supervision across the footprint.

Safeguarding supervision audit in acute and community children's safeguarding identified significant assurance in the community audit against the MFT policy standards and in acute services the snap shot review identified that practitioners had a positive experience of supervision.

Safeguarding Training

Mandatory Training

6.68 It is a mandatory requirement that all staff regardless of role/responsibility undertake safeguarding training on a 3-yearly basis, as per the Royal College Intercollegiate Documents for Adult and Child safeguarding training[58].

6.69 All staff in the Trust are mapped on the Trust 'Learning Hub' to the relevant, appropriate level of adult and child safeguarding training. It is the responsibility of the staff member and their service manager to ensure that they complete their safeguarding training.

6.70 This year the mandatory safeguarding training has been significantly reviewed and is now delivered through a modular "Think Family" course through e learning with a participatory virtual classroom for all staff mapped to level 3 training.

6.71 The Trust compliance target for safeguarding training is 90%.

Figure 35 below shows the training compliance data: the RAG rating aligns to the Trust requirements for 90% or above.

Figure 35: Mandatory Training Compliance (2022-23)

	Q1	Q2	Q3	Q4
Level 1 Safeguarding Adults e-Learning as part of corporate mandatory training	**91%↑**	**91%↔**	**91% ↔**	**91%↔**
Level 1 Safeguarding Children e-Learning as part of corporate mandatory training	**93%↔**	**92%↓**	**92%↔**	**91%↓**
Level 2 Safeguarding Adult e-Learning as part of clinical mandatory training includes Level 2 adult and MCA/DoLS training	**90%↓**	**88%↓**	**89%↑**	**89%↔**
Level 2 Safeguarding Children e-Learning as part of clinical mandatory training includes Level 2 adult and MCA/DoLS training	**89%↓**	**87%↓**	**87%↔**	**87%↔**
Level 3 Safeguarding Adults	**72/90%↑**	**70%↓**	**67%↓**	**70%↑**
Level 3 Children	**72%↑**	**72%↔**	**69%↓**	**72%↑**

6.72 Level 1 safeguarding training has remained at expecteted levels of compliance this year.

6.73 Level 2 safeguarding training has shown a decrease in compliance and is not achieving expected compliance levels.

6.74 The level 3 adult safeguarding training has shown an increase in the number of staff completing the training but, the trajectory to achieve 90% was not achieved with only 70% of mapped staff (**8,345** out of **11,962**) achieving the training. Level 3 child safeguarding training compliance remains at **72%** (**5,692** out of **7,935** of the mapped staff) achieving the training.

[58] Adult Safeguarding: Roles and for Health Care Staff (2018) 1st edition
[58] Safeguarding Children and Young People: Roles and Competencies for Healthcare staff (2019) 4th edition

6.75 The revised training programme was fully implemented in October 2022 and a Training Strategy group is overseeing implementation and impact of the new course, closely reviewing that capacity of the participatory virtual classroom meets demand. A Training Strategy is in final stages of development and will be launched in 2023-24.

6.76 In addition to mandatory safeguarding training, MFT staff are offered a range of 'bespoke' safeguarding courses, as shown in **Figure 36**. Bespoke training has focused on priority areas of safeguarding which we know requires improvement including domestic abuse and the application of the Mental Capacity Act and Deprivation of Liberty Safeguards. In addition, bespoke training has also focused on specific needs of groups of staff including internationally recruited nurses, band 3 health care support worker programme and ED staff.

Figure 36: Numbers of staff attending additional training

Bespoke Training	Numbers attending (2022-23)
Bespoke Safeguarding Adults Training	157
Bespoke Safeguarding Children Training	128
Bespoke Safeguarding Training	761
Child Sexual Exploitation Training	273
DoLS/MCA Training	628
Domestic Abuse	293
Hive and Documentation	137
LAC	62
Learning Disability and Autism Training	278
Managing Allegations Training	3
Mental Health	297
Neglect	248
Prevent Training	43

The safeguarding team has continued to provide training packs and 7-minute briefings following the publication of safeguarding reviews, learning from incidents and audits, which are shared at the safeguarding governance groups across the Trust. Thre are safeguarding podcasts to supplement learning, the podcasts available include:

- 5 safeguarding adult podcasts.
- 9 podcasts to increase staffs understanding of the care of patients with mental health concerns.
- domestic abuse podcast
- child sexual exploitation podcast
- Mental Capacity Act podcast
- 9 podcasts to support in the care of patients with a learning disabilityand/or autism.

Prevent Training

6.77 All health staff, according to their roles and responsibilities, are mapped to receive Prevent training at either Level 1-2 (Basic Prevent Awareness) or Level 3-5 (Workshop Raising Awareness of Prevent). All prevent training within MFT is delivered via e-learning. As of 31st March 2023, MFT were 90% compliant with level 1-2 training and 90% compliant with 3-5 prevent training.

6.78 Monthly compliance reports for all levels of mandatory training are now available online for managers, allowing them to monitor compliance and identify individual staff and groups who require training.

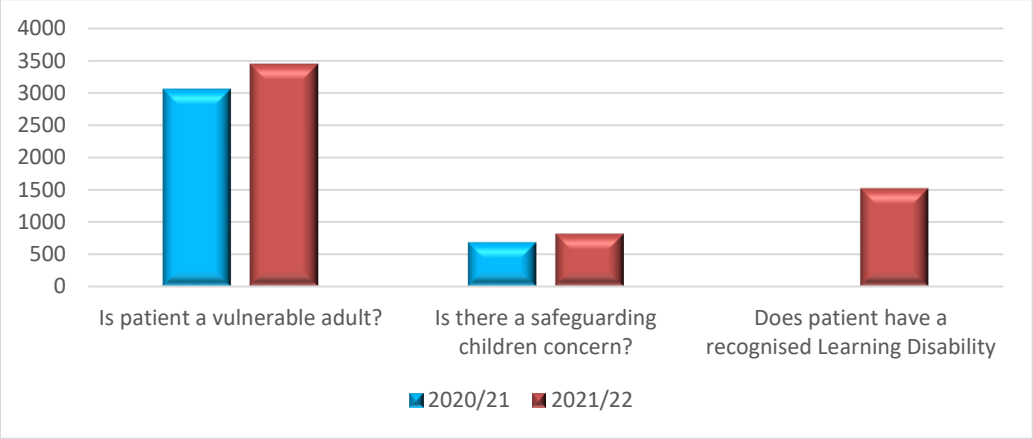
MFT Safeguarding Newsletter

6.79 The safeguarding newsletter continues to be published monthly.The newsletter supports learning and development and the disemination of best practice across the Trust. The newsletter receives very positive feedback from front line practitoners.

Incident Reporting

6.80 The Trust incident reporting system includes a facility for incidents to be categorised as safeguarding. Incident reports identify if the service user has a vulnerability, which is reflected in **Figure 37a**. All safeguarding incidents are reviewed by the safeguarding team to enable expert support and advice to be provided to the hospital/MCS/LCOs in respect of the investigation process and the safeguarding response if applicable. The safeguarding team attend the daily and weekly group safety huddle and all safeguarding related serious incident or High Impact Learning panels.

Figure 37a: Incident Reports Identifying if the Service User has a vulnerability



6.81 In this report year **4,140** safeguarding incidents were reported compared to **2,625** in 2021-2022., This evidences increasing identification and reporting of adult safeguarding concerns, which are all recorded as an incident, whilst children's safeguarding incidents are reported when expected processes are not applied.

6.82 A thematic review of safeguarding incidents is undertaken quarterly and reported to the Trust Group Safeguarding Committee. **Figure 37b** provides a summary of the annual incident themes reported by category and **Figure 37c** provides a breakdown of reporting by hospital/MCS/LCO.

Figure 37b: Incident Reporting by Category

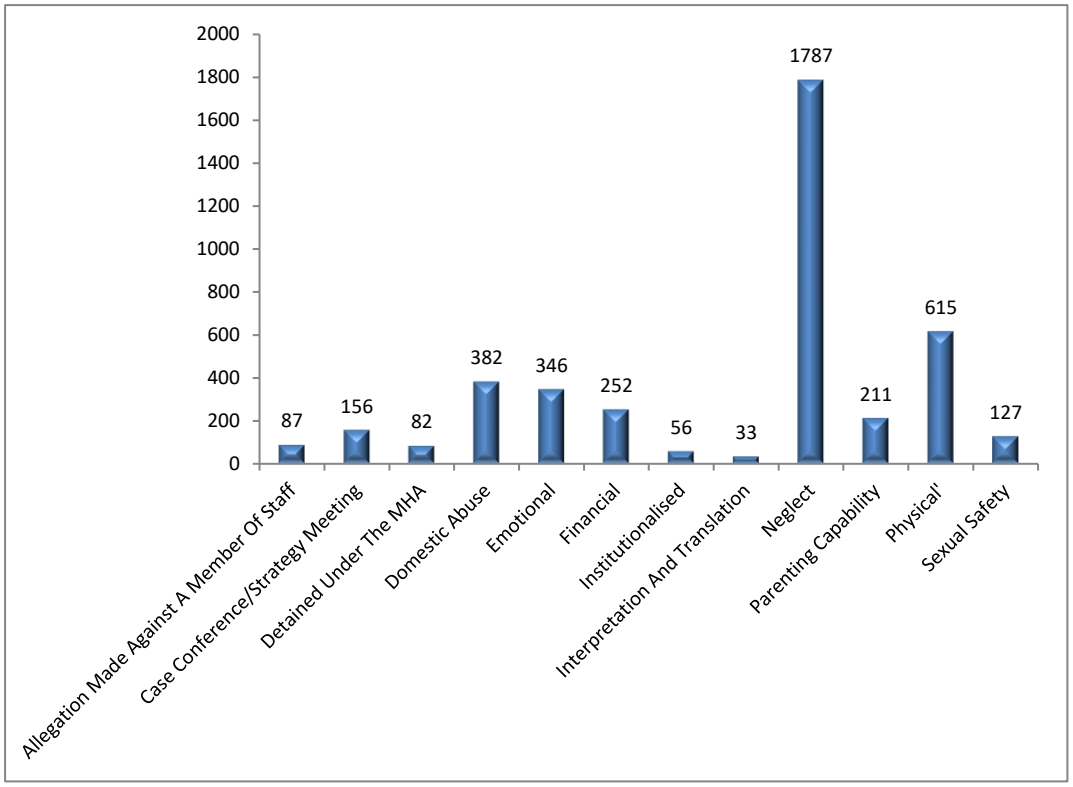
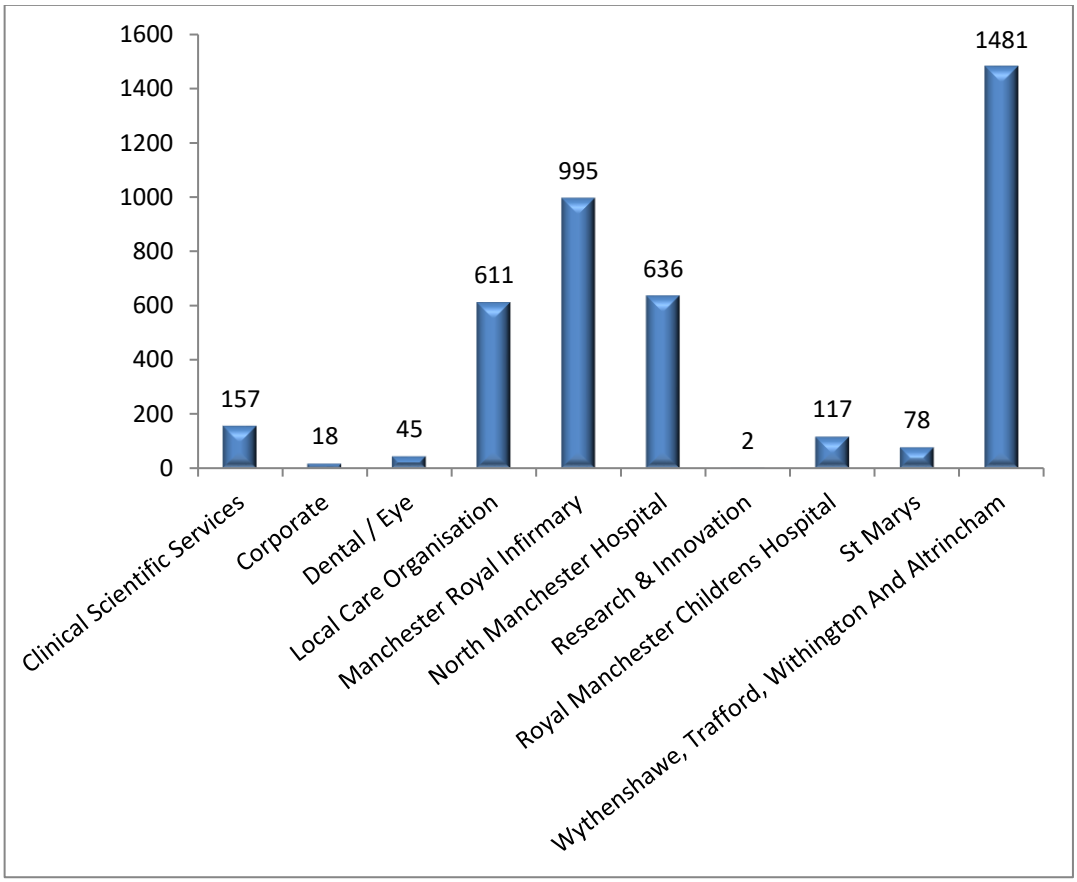


Figure 37c: Incident Reporting by Reporting Hospital/MCS/LCO



Analysis of Incident Data

6.83 MFT has a culture of transparent incident reporting evidenced by the number of safeguarding incidents reported. The safeguarding adult reporting process is closely aligned to the incident reporting process, hence the higher number of safeguarding incidents in adult safeguarding. Child safeguarding incidents are reported where the safeguarding process has not worked according to expected practice. The Trust is in line with national reporting identifying that the most frequent safeguarding incident is neglect/omission in care. This data provides assurance that the Trust recognises and responds to all allegations against staff to safeguard individuals.
This is supported through the Trust-wide 'Managing Allegations against Staff Policy' which is currently being reviewed following the review of the MSP Policy for 'Managing Concerns around People in Positions of Trust with Adults who have Care and Support Needs,[59] which has been updated this year.

6.84 The Trust has a statutory obligation to contribute to child protection case conferences and strategy meetings. An incident report is completed when services are unable to meet this requirement. Non-attendance is related to the high numbers of children on CPPs and the demand that this places on services, mainly health visiting and school nurses, who are often expected to attend up to six case conferences daily. The incidents reported this year have reduced to **73** (**82** 2021/22) this may be due to improved accessibility through child protection meetings being held virtually. Improvements in attendance at child protection strategy meetings has been identified in a local audit at the Wythenshawe hospital site.

6.85 The highest number of safeguarding incidents reported is from WTWA, MRI, NMGH and LCO. This would be expected as it is through the emergency departments, medical areas, and community services that most safeguarding concerns are recognised and actions are required/taken to appropriately safeguard.

Assurance Visits and Meetings

6.86 Unannounced safeguarding assurance visits to hospitals/MCS/LCOs have continued throughout this annual report year. These monthly unannounced visits review safeguarding at a ward/department level with feedback and actions being shared with the wards or department managers and the site safeguarding committees to support real time learning.

6.87 Compliance with CQC Regulation 13 (Safeguarding service users from abuse and improper treatment) assurance meetings are taking place by the Group Deputy Chief Nurse, Assistant Chief Nurse Safegaurding with the Directors of Nursing for the hospitals/MCS/LCO, These meetings include each hospitals/MCS/LCO providing high level assurance that they have evidence and governance systems demonstrating local activity to safeguard people from abuse and neglect.

[59] MSP Position of Trust Policy Refresh

Risk Register

6.88 The risk register is reviewed quarterly. At the end of this reporting period the following **7** risks relating to corporate safeguarding were recorded on the organisational risk register and mitigation is in place to reduce the risk:

- **Application of Deprivation of Liberty Safeguards (DoLS) lawfully**
  This is an accepted risk and relates to the pressures experienced by the LA in authorising DoLS applications within legislative timescales following applications made by MFT staff.

- **Mental Capacity Act (MCA)**
  This risk relates to implementation of the MCA across the organisation and ensuring compliance with the statutory requirements of the legislation to empower and protect adults who lack capacity to make their own decisions.

- **Looked After Children (LAC) Health Assessments**.
  It is the responsibility of the local authority to provide consent and information to health providers to enable statutory health assessments within defined timescales. Performance from the local authority is below the expected standard in sharing information in a timely way, impacting the ability of MFT to achieve compliance. Considerable multi-agency work has been completed to address this.

- **Use of ligatures as a means of self-harm.**
  A Suicide Prevention policy and training has been implemented to mitigate this risk.This year local site safeguarding committees have had oversight of completion on environmental ligature risk asssments in inpatient ward areas and to monitor ligature incident management training.

- **MHA application according to legislation**
  If a patient is not detained appropriately under the Mental Health Act (MHA) 1983, patients may be placed at risk and the organisation exposed to legal challenge. The Trust's mental health act administrators track and monitor compliance with the MHA.

- **MHA Sections Expiry prior to patient's formal assessment by an approved mental health professional and admission to a place of safety**
  This risks identifies the legal authority to detain a patient when a MHA section expires, identifying the requirement for a clearly documented risk assessment as to why and how the powers are employed. The MHA policy has been updated to articulate expected practice to mitigate this risk.

- **Implementation of Child Protection Information Sharing System (CP-IS)**
  CP-IS is a NHS England mandated information system in unscheduled and urgent care settings to inform health practitioners and the Local Authority Children's Social Care if an unborn, child or young person who is subject to a child protection plan or looked after by the Local Authority has attended urgent or unscheduled care. There is not full assurance that CP-IS is fully implemented in Emergency Departments and Urgent Care, a revised MFT CP-IS guidance has been produced and all areas are working towards assurance to demonstrate implementation. St Mary's Maternity Triage and Emergency Gynaecology Units plan to fully implement CP-IS in Q2 2023/24.

Safeguarding Audit

6.89 The audit plan aims to review how the Trust is meeting its statutory and regulatory responsibilities, evidencing safeguarding against the GM Safeguarding Contractual Standar[60] and reviews the implementation of learning following SAR/SCR/CSPR/DHR recommendations.

6.90 This year **37** MFT safeguarding audits or local dip sample/point prevalence reviews were included on the plan with **29** completed and **8** to be finalised in 2022-23. The completed audits reviewed safeguarding practice in the following areas:

- ✓ **Safeguarding children and the unborn.**
  Audits were completed in safeguarding documentation process in community and maternity as well as a review of practice for children impacted by child sexual exploitation. Safeguarding supervision audits showed the workforce had a positive experience of supervision and significant assurance in application of policy standards in community safeguarding supervision. An audit was completed to review application of the preventing abusive head injury (ICON) pathway identifying significant assurance in ST Marys' ORC but a need to embed the programme at WTWA and NMGH.
- ✓ **Looked after Children (LAC)**
  An extensive LAC audit programme of **8** audits were completed to provide a deeper insight to the LAC performance KPIs including audit of health assessments and documentation, access to dental services, recording of obesity in LAC, and use of Strength and Difficulties Questionairre. Audits were completed to review the health response to vulnerable LAC children including unaccompanied asylum seeking children (UASC) and LAC placed at home. Positively audits of the voice of the child and young person in health assessments and the understanding of the role of the LAC nurses by UASC identified significant assurance.
- ✓ **Adult Safeguarding and vulnerable groups**
  5 reviews were completed into the application of Mental Capacity Act, use of advocacy services and the DoLS process identifying the need to continue to provide training and support to enablet consistent application of MCA and DoLS. Care of vulnerable groups was reviewed through review of the use of hospital passports for patients with a learning disability and or autism, a review of nutrition and hydation needs in high risk patients and compliance with the integrated pathway for self-harm and suicide and the application of the suicide prevention policy was reviewed.

[60] Clinical Commissioning Groups Safeguarding Children, Young People and Adults at Risk Contractual Standards 2022-23 A Collaborative Greater Manchester (GM) Document The trust is required to submit evidence against 67 safeguarding standards in APPENDIX 2: 2021-2022 - NHS PROVIDER SAFEGUARDING AND LOOKED AFTER CHILDREN AUDIT TOOL

- ✓ The Trust completed the Annual MSP Section 11 audit with a rag rating of green being achieved in all areas. The MSP Adult Assurance audit identified the Trust met 12 out of 13 expected standards but that further work is required in 2023/24 to ensure consistent application of the Mental Capacity Act at the frontline and in the recognition and response to self-neglect.

Multi-agency Audit

- ✓ In addition, the Trust completed **6** contributions to the TSSP/MSP/GM multi-agency audits in self-neglect in adult safeguarding, mental health and child exploitation. A True for Us Review was completed to benchmark the Trust and MSP against strategic and operational responsibilities identified in National Safeguarding Practice Review Panel following the death of Arthur Labinjo Hughes and Star Hobson[61].

  Recommendations and learning from audits were overseen by the Trust Quality and Learning Subgroup and shared via the site Safeguarding Committees.

[61] National review into the murders of Arthur Labinjo-Hughes and Star Hobson

SECTION G
Safeguarding Team Achievements 2022-2023

7. Safeguarding Team Achievements 2022-23

Delivery of Safeguarding Work Plan 2022-2023

7.1 MFT has continued to prioritise the delivery of its statutory safeguarding obligations. The safeguarding team has supported the Trust to maintain safeguarding service delivery through safeguarding meetings, training, policy development, support and supervision. Safeguarding newsletters, briefings and safety alerts have been cascaded across the Trust in responses to change in legislation, national learning and local learning themes across the safeguarding partnerships. This year has seen close working relationships with the Patient Safety team, with the safeguarding team now attending Group Safety Huddle on a daily basis. The safeguarding teams have developed close working relationships with site Risk and Governance teams with oversight from the Group Patient Safety team which has resulted in a consistent safeguarding consideration in the Trust response to section 42 adult safeguarding enquiries, CQC enquiries and complaints where there are safeguarding concerns.

7.2 The "Think Family" whole family approach has been promoted in the delivery of safeguarding with the safeguarding teams of safeguarding adult and children practitioners, midwives, learning disability and mental health nurses supporting the delivery of a highly visible and approachable safeguarding team across MFT.

7.3 **Figure 38** summarises the outcomes achieved through the delivery of the MFT safeguarding audit and work plan in 2022-23.

Key Priority	Key outcome	Achieved	
Making Safeguarding Personal	To ensure making safeguarding personal/listening and hearing the voice of the child/young person/'and adult at risk including "What Matters to Me' is embedded in all safeguarding operational and strategic practice.	✔	Safeguarding training, audit, supervision and assurance visits has identified the voice of the child, young person and adult at risk, is captured in safeguarding and looked after children practice.This year Trafford community have focused on hearing the child's voice throughi enabling staff to use "Impact Chronologies" to stregthen safeguarding practice.
	All hospitals/MCS/MLCO are aware of the need to include the child and vulnerable adult's wishes and views in all safeguarding decisions.	✔	The Manchester community team worked with MSP to hear the voice of children and young people in the child protection process. The safeguarding assessment developed in Hive electronic patient record includes assessment of the voice of the person at risk.

			There is feedback from our service users is collected through what matters to me, friends and family testing and the RMCH Youth Forum. A point prevalence survey of advocacy services identified that staff understood the importance of using advocacy services and briefings have been completed to increase staff awareness of referral to advocacy services.
	The safeguarding work plans identify strengths and areas for development identified within hospitals/MCS/MLCO and there is evidence of plans to manage any gaps in practice areas.		All safeguarding work plan's have been reviewed quarterly at the Quality and Learning Committee. Group, thematic and site safeguarding committes included patient stories and review of safeguarding cases to champion our service user experience. MFT have shared patient stories hearing the voice of children, young people and adults at risk in MSP strategic meetings.
	Safeguarding adult and children champions are in place across all frontline areas.		The safeguarding champions network is in place which has focused on "Think Family" safeguarding. MFT safeguarding children team had a stall at the MSP children's conference where the children shared what mattered to them in Being Healthy and Safe. The Assistant Chief Nurse Safeguarding has been the Safeguarding Children's Champion for the Manchester Pupil Parliament supporting their safeguarding mental health project.

Adult and Children's Safeguarding **Keeping People Safe**	Safeguarding adults and children at risk remains a priority to the Trust		Annual Adult Safeguarding Assurance, Section 11 Audit and Completion of GM Contractual Standards have been completed with action plans in place to evidence safeguarding standards in the Trust are met
	There are systems and processes in place to recognise and respond to risk in unborn, children, young people adults at risk and their families		The Hive EPR has been implemented across hospitals/MCS which includes prompts for staff to "Think Safeguarding", Safeguarding Assessment tools, an order for requesting safeguarding advice and capacity for documentation of safeguarding concerns and risk maagement plans. The Safeguarding governance groups have all been held with oversight of attendance at Group Safeguarding Committee
	Policies and practice are reviewed and updated within timescales and all divisions receive timely updates.		All safeguarding policies are up to date and have been reviewed in line with Hive implementation. A focus on mental health has seen all mental health policies streamlined to be more "user friendly" and applicable to frontline practice.
	Hospitals/MCS/MLCO have provided assurance that these have been embedded across all relevant staff groups.		Regulation 13 Annual Assurance visits have been completed Safeguarding unannounced assurance visits have been completed. During May 2022 a business continuity plan at NMGH folowing an IT outage ensured safeguarding concerns were continually raised and appropriately actioned.

Adult and Children's Safeguarding Training	To work in partnership with hospitals/MCS/LCO to improve training compliance to expected 90% compliance levels		Safeguarding training has been delivered and compliance is monitored through Group and Site Safeguarding Committees.
	To review the level 3 safeguarding training in line with the Trust's review of mandatory training		The mandatory safeguarding training has been reviewed and a new "Think Family" streamlined adult and children's safeguarding training package has been implemented which includes e learning supplemented by a virtual classroom for level 3 safeguarding training. A Training Strategy Group has been established to support the delivery of safeguarding training and to continue to support hospitals to achieve the target of 90% compliance which has not yet been achieved for level 3 training
Supervision and support	All staff has access to supervision and support relevant to their area of work.		The safeguarding supervision policy has been reviewed to incorporate the revised MSP Escalation and Resolution Policy and learning from MFT Safeguarding Supervision audit.
	Community safeguarding supervision compliance is above 90% for all relevant staff.		Community safeguarding supervision in the majority of areas has been above 90% compliance in Manchester but further work is required to achieve consistent compliance in Trafford. A safeguarding supervision audit demonstrated significant assurance against policy standards.
	Supervision developed in areas such as CAMHS, Royal Manchester Children's Hospital, St Marys, and sexual health services		Safeguarding supervision has been strengthened across the acute footprint including new "Think Family" supervision sessions and snap shot supervision sessions. A snapshot audit identified staff had a positive experience of supervision but work was required to increase attendance of senior staff and monitor compliance

Looked after Children and Care Leavers	All services are enabled to effectively safeguard, protect and promote the welfare, health and wellbeing of looked after children and young people and care leavers		The looked after children subgroup has representation from across the Trust. Looked after children training has been provided in line with Intercollegiate Guidance[62] A LAC Annual Report has been completed
Mental Capacity Act (MCA) **Deprivation of Liberty Safeguards (DoLS)** **Liberty Protection Safeguards (LPS)**	Staff have an increased understanding of MCA/DoLS across the Trust. Staff understand their role and responsibility and are following guidelines		A module on MCA and DoLS is now included in mandatory safeguarding training. Bespoke additional training has also been provided, this has included training from legal services on application of Court of Protection DoLS for children and young people. Internal audits, incidents and external reviews have identified the need to raise awareness and support MFT staff in the application of the Mental Capacity Act, resulting in the development of further training and 7 minute briefings.
	To work with hospitals/MCS/LCO on the implementation of LPS		MFT contributed to the Consultation of the Code of practice and have held an LPS implementation group. The LPS group will focus in 2023-24 to MCA “Getting it Right in Practice”.
Raising Concern/Managing Allegations	There is a culture where staff can raise concerns		The Managing Allegations against MFT Staff who work with Children and has been reviewed in line with updated MSP Policy for Managing Concerns for People in Positions of Trust who have Care and Support Needs. Updated local training has been developed and delivered.
Complex and wider safeguarding	Staff contribute to the wider safeguarding agenda and know how to escalate concerns to the needs of vulnerable groups		Trust thematic safeguarding sub groups have been held with representation from across the MFT footprint. MFT have supported the Manchester and Trafford Complex Safeguarding weeks of action.

[62] Looked after Children: roles and competencies of healthcare staff

			MFT have worked with multi agency partners to implement Manchester and Trafford Neglect and Domestic Abuse strategies.
Safeguarding in the Context of a Citizen with Mental Health Needs or Learning Disability	There are systems and processes in place to enabler staff to recognise and respond to the needs of people with a mental health condition and learning disability/autism		The Safeguarding Mental Health and Learning Disability/Autism team are established across MFT footprint to support the frontline services in making reasonable adjustments to provide high quality services to patients with a learning disability/mental health condition. Hive implementation has enabled flagging of patients detained under the Mental Health Act and flagging people with a learning disability and/or autism which has supported assessment and care planning in reasonable adjustments. Mental Health Policy guidance has been reviewed to ensure policy supports frontline practioce and has been incorporated to include the use of Hive to documenting care and tratment. A Learning Disability Policy for patients in hospital has been developed.
Accountability/ Accessing Information/Documentation	Trust adheres to legal and professional safeguarding documentation standards		Implementation of Hive has facilitated documentation of safeguarding in the EPR and introduced a consistent approach to completing a safeguarding order/consultation with the safeguarding team. Following the Hive implementation, immediate contigency strategies were implemented to monitor and ensure safeguarding concerns were acted upon whilst the safeguarding build was optimised in September and October 2022.

			Safeguarding documentation and referral audits have been completed across the Trust
Partnership/Information Sharing	To ensure key messages from local and partnership groups are shared with the Trust through safeguarding governance groups. To ensure there are robust processes in place and learning is disseminated to all areas from Serious Case Reviews/Child Safeguarding Practice Reviews/ Safeguarding Adult Reviews and Domestic Homicide Reviews	✓ ✓	There is a clear reporting governance structure to share messages to and from MSP TSSP and within MFT. The safeguarding newsletter was produced monthly and shares learning from local and national safeguarding reviews, legislaticve guidance policy and practice guidance MFT have contributed to all requests for partnership safeguarding reviews with learning and review of actions cordinated through the Quality and Learning group.

7.4 The key achievements of the MFT safeguarding teams by team

7.4.1 Midwifery Safeguarding, ORC, NMGH and WTWA

Name of Team	**Safeguarding Maternity - ORC, NMGH and WTWA**
Has the team delivered on actions within the safeguarding work plan 2022-23	• All objectives for Making Safeguarding Personal for Maternity clients were achieved; with women being involved in their safeguarding care plans wherever possible and support offered by specialist midwives for young parents, women suffering with mental health or substance abuse concerns, and women seeking asylum or refugee status. • The Integrated Safeguarding Team were able to support each other with the "Think Family" approach and were involved in sharing support for both maternity and adult nurses within safeguarding concerns. • The Named Midwives meets monthly with the Head of Midwifery to ensure that all safeguarding incidents are discussed, and actions taken appropriately; and to discuss recurring safeguarding themes and bespoke training within maternity. • Planned audits in Q1 in St Marys's NMGH on application of the Safeguarding FGM policy[63] and documentation of safeguarding concerns identified poor compliance in expected standards. Following a successful action plan focussing on staff training, re-audits were completed and significant assurance achieved. • There has been an increase in safeguarding supervision provision, this has been well received by midwives and compliance with all safeguarding supervision has increased. The group supervision for specialist midwives now takes place virtually and invitation has been extended to equivalent midwives at NMGH and WTWA. This has promoted cross-site working and collaboration within maternity services. There is regular monitoring to ensure attendance. Safeguarding Supervision has continued with group supervision and 1:1 supervision for Community Midwives, Team Leaders, and Specialist Midwives. This includes supervision for the Judicial Midwife who is based at HMP Styal.

[63] MFT Prevention, Recognition and Safeguarding Women and Girls from Female Genital Mutilation Policy

	• Bespoke Safeguarding training is provided to midwives and maternity support workers, including ICON[64] training and learning from CSPR's /SAR's.
Key achievements	➢ Hope Boxes are being offered to women who are at risk of child care public law care proceedings being initiated following birth. This box contains memory making items to enable memories to be made for both mum and baby.   ➢ Safeguarding Champions have been identified in all clinical areas in NMGH within the hospital, including antenatal clinic, antenatal and postnatal wards, labour ward and the neonatal unit. ➢ In- order to reduce the incidence of Abusive Head Trauma in babies, the ICON pathway has been introduced successfully across Manchester and Trafford, Salford and Bury. Training for Midwives and Maternity Support Workers at NMGH continues to be provided and there is an on-going rolling program to ensure all previously absent staff and new starters are included. ➢ Safeguarding Midwives have provided written and face to face guidance for managing safeguarding concerns on Hive to all acute staff where required. ➢ All disclosures of Female Genital Mutilation are now formally risk assessed, by use of Department of Health (2018) FGM Risk Assessment, which has been added to the Maternity Information Referral Form used across 3 sites. Safeguarding Midwives record data of disclosures on the National FGM portal. Children who are assessed as at risk of FGM are referred to Children's Social Care. All disclosures are copied to the Safeguarding Midwives Team to support monitoring and follow up. All female infants born to women who have disclosed or have been identified as having FGM, are recorded on the NHS National Spine, for information sharing with other health professionals throughout their childhood. ➢ The on-site IDVA, provided by Midwifery and Domestic Abuse Support Service [65] provides bespoke a specialist domestic violence and abuse Independent Domestic Abuse Advocate Service in St Marys and supports domestic violence and abuse training. ➢ At the Wythenshawe site, Snapshot Training has been implemented for the Emergency Gynaecology Unit to provide additional support and training enabling the staff to be more confident in meeting their safeguarding obligations. This will also focus on themes and missed opportunities following incidents. ➢ The Safeguarding Midwives attend the NICU Away Days for Band 6 and Band 7 to provide additional support and training enabling the staff to be more confident in meeting their safeguarding obligations. This will also focus on themes and missed opportunities following incidents. .

64 ICON Programme aims to prevent abusive head trauma in babies

65 Midwifery and Domestic Abuse Support Service

Manchester Children's Community Safeguarding

7.4.2 Manchester Safeguarding Children Community Team

Name of Team	Manchester Community Safeguarding Team
Has the team delivered on actions within safeguarding work plan	• MLCO/TLCO and CAMHS safeguarding supervision audit was completed which gave significant assurance compared with the previous audit which gave limited assurance. An action plan has been developed to review some areas of supervision including the group supervision offer to make it more consistent across the wider safeguarding team. • The Manchester locality Safeguarding Children Fora are chaired by Named Nurses Safeguarding Children and are attended by acute and community safeguarding practitioners. Central and North localities have held joint child and adult fora. The south locality also plans to hold a joint forum to promote a 'Think Family' approach. ➢ A Named Nurse from the team has led a task and finish group to produce a pathway for the Management of Non-Mobile Infants with Bruising (or other injuries) or Newly Visible Marks in the Community Setting consulting with Named Nurses/Doctors and Midwives and Specialist Practitioners from the acute and community teams to ensure that referrals to paediatricians are proportionate, timely and well communicated. This has involved a robust literature review exploring the evidence based including learning from the National Child Safeguarding Review Panel. • Work is being undertaken to improve communication between CAMHS and the safeguarding teams and ensure they have the correct contact details for the team allocated to providing safeguarding support and advice. Scoping has been undertaken to identify gaps and inconsistencies in the CAMHS supervision offer with a plan to work across sites to ensure the offer is smart and equitable. • The Named Nurses have been keeping up to date with the changes to Manchester's Safeguarding and Review Service's family-led child protection conference model. The team has also supported a multiagency audit of the quality of case conference reports and shared their learning with the Quality and Learning Subgroup and site safeguarding committee. The dissemination of demographics of children subject to safeguarding flags (known as 'banded lists' by Child Health has been reinstated, to support the supervision process. • The team are represented by a Named Nurse at the Healthy Weight Clinical Steering Group. A process has been developed to strengthen communication between the healthy weight and early help and neglect workstreams. A report from the Healthy Weight Clinical Steering Group will be shared at the Early Help and Neglect Subgroup and the Named Nurse Lead for Healthy Weight will attend the subgroup annually. Going forward, the team plans to promote mapping against the Manchester Healthy Weight Strategy and the MSP Neglect Strategy within the Healthy Weight Clinical Steering Group.
Key Achievements	➢ Partnership Working – work has been commenced to develop a Standard Operating Procedure for the provision of safeguarding advice to GP practices within the city of Manchester. A thematic review of safeguarding consultations is informing this work stream. ➢ Safeguarding Children – the children's Community Safeguarding Team have piloted a pathway for Fabricated and Indiced Illness (FII)//Perplexing Presentations (PP) which has strengthened coordination and communication with frontline practitioners and medical colleagues and ensured an individualised approach is taken to case management. This will support the multiagency pathway for FII/PP. ➢ A Prevent training package was developed and delivered to the wider safeguarding team to increase knowledge and understanding in this complex area of safeguarding.

	➢ A strategy meeting audit was completed in early 2022 followed by a multi-agency Strategy Task and Finish Group to look at the findings from the audit. An initial action plan has been drawn up and comments shared. ➢ The monthly Safeguarding Newsletter enables safeguarding information to be disseminated across the Trusts and LCOs, including key messages from the safeguarding partnership, lessons learned, safeguarding training and local and national safeguarding issues ➢ A CSE audit was completed to look at the quality of practice involvement from school nurses, LAC nurses and Specialist Nurse CSE.

Manchester and Trafford Community Service

7.4.3 Manchester Children's Community Named Doctor

Name of Team	**Named Doctor Safeguarding Children Community including Child Protection (Community) Clinic Children's Community Paediatrics - Manchester Local Care Organisation**
Key achievements 2022-23	➢ A new Named Doctor Safeguarding Children came into post on 1st September 2022. ➢ Peer review of child protection medical assessment is robust, held every 2 weeks. ➢ The Community Paediatric Service is currently benchmarking its peer review process against the new Royal College of Paediatrics and Child Health (RCPCH) process and an updated process is expected to be considered by the team later in 2023. ➢ The community paediatric service runs Continuing Professional Development (CPD) sessions for medical and nursing members of the team once a month. This is an opportunity to enhance the mandatory training opportunities within the Trust and consider additional topics ➢ The Coral Suite has recently been awarded a £5000 grant from a children's charity to improve facilities with a particular focus on the needs of adolescent children. ➢ A task and finish group has been set up by the MSP look at the section 47, Children Act 1989 process for children – MFT is taking part and the named doctor at the MLCO sits on the group ➢ The Coral Suite has recently reviewed the child protection proforma and will now look at reviewing the template for medical reports ➢ A visit was hosted by His Majesty's Lord Lieutenant of Greater Manchester who was keen to learn more about our safeguarding medical services and safeguarding assessments of children who are in the care of the State

7.4.4 Trafford Safeguarding Children Community Team

Name of Team	**Trafford Safeguarding Children Community Team**
Has the team delivered on actions within safeguarding work plan 2022-23	• The court report process for public law childcare proceedings has been streamlined, to bring in line with the court report template already used by the MFT services for Manchester families, this has improved the quality of the reports and demonstrated impact on the child/ young person where there are safeguarding concerns. • The team has continued to support the TSSP multiagency training agenda including delivery of neglect and obesity training. • There has been representation at the TSSP multiagency sub groups from the Trafford Safeguarding Community Team and the TLCO. • Safeguarding Supervision is now being delivered face to face.
Key achievements	➢ Staffing within the Trafford Community Safeguarding Team has stabilised and relationships with the Trafford Local Authority and TLCO have been strengthened. ➢ The safeguarding team have supported TLCO staff to utilise Impact Chronologies to support multi agency escalation of concerns around child neglect.

	➢ TLCO and Trafford Community Safeguarding Team have provided practitioners to support the forthcoming multiagency training sessions around Graded Care Profile and Impact Chronologies. ➢ Named Nurse Safeguarding Children and Children in Care has attended the MARAC Chair training. ➢ Bespoke training has been delivered to MFT staff and as part of the multiagency training pool focusing on the TSSP Key Priorities 2022-2025.

7.4.5 Trafford Children's Community Named Doctor

Name of Team	**Named Doctor Safeguarding Children Community including Child Protection (Community) Clinic** **Children's Community Paediatrics - Trafford Local Care Organisation**
Key achievements 2022-23	➢ There has been a strengthened working relationship with children's social care due to increased collaboration and agreements in ways of working. ➢ The venue and the nursing support have improved following the relocation to the children resource centre in Trafford hospital. ➢ There has been five cases of fabricated and induced illness/perplexing presentations in the last year, four of them being complex cases ➢ Registrars are getting induction training, clinical supervision, and peer review support in safeguarding ➢ There are regular peer review meetings to discuss all the safeguarding cases.

7.4.6 Safeguarding Children, ORC, NMGH and WTWA

Name of Team	**WTWA, ORC, NMGH Safeguarding Children Team**
Has the team delivered on actions within safeguarding work plan	• Safeguarding children's acute team have standardised all acute safeguarding processes across Trust to provide a consistent streamlined response across ORC, WTWA and NMGH. The implementation of Hive has supported this process. • Safeguarding Supervision using a Think Family approach has been strengthened across the footprint via: ➢ An increase in the offer of generic group sessions for staff ➢ An increase in the offer of bespoke sessions for staff ➢ An increase in the offer to targeted medical and nursing teams (Paediatric Intensive Care (PICU), Paediatric Emergency Department (PED)) ➢ Introduction of 'snapshot' safeguarding supervision in Emergency Departments. ➢ Introduction of wider Senior Nursing Leadership to the safeguarding weekly huddles This has resulted in an increase in the uptake of safeguarding supervision. • The voice of the child and young person has been embedded into Hive admission and safeguarding documents which were implemented in September 2022. The safeguarding team has supported hospitals in training, "tip" sheets, advice and guidance in using Hive to document safeguarding activity and concerns, as well as contributed to improvements in the system. • MFT Management of Children & Young People in Crisis who Require an Inpatient Admission as a Place of Safety guidance[66] has been shared via site safeguarding committees and support with implementation offered, this has provided a framework to guide the safeguarding response to this vulnerable group of patients. This has informed the collaborative working with RMCH/MRI/NMGH/WTWA to benchmark against CQC standards for children and young people in hospital as a place of safety • The "Think Family " approach has informed the increased visibility of safeguarding children teams within adult ward areas including implementation of ED and urgent care safeguarding meetings..

[66] Local MFT Management of Children & Young People in Crisis who Require an Inpatient Admission as a Place of Safety guidance in response to Greater Manchester Children in Crisis Framework

Key Achievements 2022/3	➢ The Safeguarding Champions meetings have been relaunched using a "Think Family" approach working closely with the safeguarding adult team. ➢ The teams have promoted specific safeguarding issues in emergency departments (ED) and targeted ward areas to increase recognition and response to safeguarding during weeks of action in 'child exploitation week', 'Domestic Violence and Abuse 16 days of action' and ICON awareness week. ➢ There has been a review of Child Protection-Information Sharing (CP-IS)[67] system implementation and guidance across MFT following the introduction of the new Hive electronic record in all adult and children unscheduled care settings. ➢ Provision of bespoke safeguarding training has been provided (in response to identified safeguarding need and risks) at NMGH, WTWA and RMCH. This has included bespoke training on safeguarding referrals, safeguarding induction (Nursing and Medical), domestic abuse and managing allegations training to RMCH Modern Matrons and Ward Managers. There is ongoing contribution to the development of safeguarding training for ED Nurses and International Nurses.

7.4.7 Named Doctor Acute, ORC, NMGH and WTWA

Name of Team	**Named Doctor Safeguarding Acute ORC, NMGH and WTWA**
Key achievements 2020/21	➢ The Safeguarding Management of Injuries in Infants guidance [68] has been updated to take into account of new guidelines and to include NMGH in the guideline. This guideline highlights the importance in recognising injuries in infants and to support staff in the emergency department and the paediatric wards in initiating the correct safeguarding response when an infant is brought to hospital with an injury. The Named Doctors are providing regular teaching sessions to the Emergency Department staff and paediatric staff. ➢ Bespoke safeguarding training has been provided for new middle grade paediatric doctors, who have just started working in the UK (and MFT), to inform them about safeguarding children procedures in the UK . ➢ At Wythenshawe Hospital audit has shown a high standard of documentation in child protection medicals. ➢ At Wythenshawe Hospital a regular training sessions on writing Child Protection Medical reports has been introduced for middle grade doctors and consultants. ➢ Safeguarding Peer Review is established at all three sites with good attendance of medical and nursing staff and meets the standards required by RCPCH[69]. ➢ The pathway for the Management of Fabricated and Induced Illness/Perplexing Presentations has been implemented across Manchester, led by the Designated Doctor for Manchester Integrated Care Board. ➢ The introduction of HiveI (new patient electronic records) throughout MFT has led to both opportunities and challenges in acute paediatric safeguarding with further work on developing the child protection medical template a priority for 2023-24.

7.4.8 Acute Safeguarding Adults

Name of Team	**Adult Safeguarding Team, Oxford Road Campus (ORC), Wythenshawe Trafford Withington and Altrincham (WTWA) Teams and North Manchester General Hospital (NMGH)**
Has the team delivered on actions within safeguarding work plan	• The safeguarding adults team have supported the wards with the implementation of Hive. A 'Safeguarding How To Guide' was developed and disseminated across the safeguarding teams to enable them to support staff correctly. • Safeguarding training has successfully moved to e-Learning modules, but the team has also recognised the need to adapt support via face-to-face training in some areas and this is regularly carried out covering a range of topics to recognise, respond, escalate and refer. This includes training for Internationally Recruited Nurses. This training is delivered in conjunction with children's,

[67] Child Protection- Information Sharing (CPP-IS)
[68] MFT The Safeguarding Management of Injuries in Infants guidance
[69] Child Protection and Safeguarding in the UK

mental health and learning disability/autism safeguarding teams to ensure 'Think Family' approach. There has been positive feedback from both participants and the education team.

- The WTWA team contributed to Trafford theatres ace day delivering a 'Think Family' safeguarding session in conjunction with the safeguarding children's team (see below).

At ORC new informal "How to" training sessions have been introduced to all staff to boost staff confidence around assessing mental capacity. This is a different approach to MCA training, delivering in an informal, conversational style. This is delivered monthly, as a virtual, drop-in session.
The ORC team are offering bespoke tool-box training sessions. These are 10 minutes sessions at the nurse's station embed the basics of safeguarding.

- The WTWA Safeguarding Adults team have begun to re-establish the quarterly safeguarding champions meetings with a key focus on 'making safeguarding personal' There has been partnership working with the Quality and Improvement senior team to ensure compliance across WTWA. In NMGH the quarterly safeguarding champions meetings are co-hosted on the site with adults, learning disability nurse and children's safeguarding colleagues to cascade information to front line practitioners with the use of guest speakers such as complex safeguarding team, presentations & patient stories, as well as affording space for practitioners raising questions & suggestions with a 'Think

	family' approach. Attendance at the divisional ward managers meetings also gives further direct links to front line staff by the safeguarding team. • The WTWA Safeguarding Adults team have redesigned the managing allegations training. A sample training session was undertaken, feedback for this was positive, allowing the team to plan the embedment of this training in the near future. In NMGH, a programme of actions was developed to support a culture that focussed on 'making safeguarding personal' actions to promote this included observational rounds, supporting serious incident panel action plans to ensure safeguarding elements are included, safeguarding supervision and fostering a culture of where staff, patients and loved ones feel secure in raising concerns, as well as additional bespoke training. • The WTWA Safeguarding Adults team have continued to attend the WTWA Falls Accountability panel. There is now attendance at the accountability meetings for both TLCO and South MLCO to expand on accessibility to the safeguarding team. In NMGH, the safeguarding team participate in the accountability meetings for both falls and pressure ulcers in the acute and North LCO settings to ensure any harm caused is correctly identified and the voice of the adult is heard. The ORC team have sustained attendance and participation in the Harm Free Care agenda, highlighting falls and pressure ulcers including a high impact learning assessment to explore ways in reducing harm. • Safeguarding supervision has been strengthened this year. The team at NMGH have commenced a rolling programme of 'Think Family' safeguarding supervision within the Accident & Emergency department to support staff in their decision making. Supervision session's either individually and/or in a group have also been initiated on the acute site and North community settings with good feedback from participants and the opportunity for them bring current cases. The WTWA Safeguarding Adults team have implemented quarterly safeguarding supervision sessions for all TLCO staff. The demand for these sessions has increased with all sessions being fully booked and bespoke sessions being offered. The team have received positive feedback and have noticed an increase in the compliance of accurately completed safeguarding adults referrals. At ORC, the introduction of monthly safeguarding 'Ask the Teams' supervision sessions has been implemented with the central team MLCO. This is well attended and provides community teams with a platform to discuss safeguarding in a supportive and educational format. • At ORC, monthly safeguarding supervision sessions have been launched with security teams, as staff who provide security support often manage sensitive and emotional situations. • In NMGH, when the local authority has requested information to inform safeguarding enquiries the team identified a theme around unsafe discharges. This was escalated quickly to Heads of Nursing and a plan around supporting safe discharges implemented by the divisions. All incidents and referrals are monitored by the team for themes and trends so these can also be escalated quickly by senior managers. The last year has seen the embedding of a more streamlined process to response to local authority safeguarding enquires. • Partnership working at NMGH has also increased with the weekly 'missing person's' meeting chaired by the police and attended by Greater Manchester Mental health colleagues, A&E matrons and security colleagues. The meetings have not only assisted in 'closing the loop' around the attendance for MFT but have highlighted how the police triage levels differ to MFT policy making clinical staff more aware when referring for a welfare check and built a greater understanding in the partnership.

Key Achievements	➢ Adult safeguarding week gave the team and clinicians chance to refresh themselves with the under-pinning principles of the Care Act. During Safeguarding Adults Week, the WTWA Safeguarding Adults team visited all areas across WTWA. There was a competition for wards/departments to submit their safeguarding board and a quiz for all staff to complete. With support from a wide range of charities across the Greater Manchester area, useful resources and prizes were disseminated with frontline staff.

- There has been local analysis and review of the DoLS process. This year NMGH saw further alignment with MFT policies and procedures including the move from the Evolve electronic records system to Hive record system and within that the change in DoLS application process. Data collections showed a steady number of referrals throughout the change in systems.
  At ORC there was the implementation of weekly DoLS cross referencing meetings with the local authority DoLS team. This has seen a significant reduction in the patients who are waiting for a standard DoLS authorisation, by removing inappropriate referrals from the local authority DoLS team waiting list. It has also seen a marked improvement in communication between MCS DoLS team and the ORC safeguarding team.
- In ORC a point prevalence exercise around the use of advocacy services in the Trust has been completed. The aim was to determine if staff understood the importance of providing an advocate to support the voice of those patients who cannot advocate for themselves.
- Data suggested that staff have an excellent awareness of when advocacy was lawfully required but were unsure of how to access these services. In response the team developed a 7-minute briefing to provide this information across the Trust.
- In ORC, following the recruitment of a Named Practitioner, the team have worked hard within quarter 4 to improve the visability and accessibility of the team, ensuring daily visits to high acuity areas (ED, AMU, Eye ED). The photo shows the safeguarding matrons meeting with senior ED team.

- The WTWA Safeguarding Adults team has undergone a full change in the staff team with the exception of one staff member. This contributed to the development of 'in house' training sessions for all new starters.
- NMGH team successfully recruited into the senior adult safeguarding nurse post with a specialist focus on community safeguarding . The aim will be to enhance safeguarding supervision, bespoke training around community concerns and supporting patients and staff in receiving care in the community.
- The safeguarding support to Trafford General Hospital has been strengthened to establish strong partnership working across the site. The team currently work from Trafford General Hospital two days per week to offer face to face support. The focus during these days is to increase the visibility on the wards/departments, this is notable in the increase of advice cases and safeguarding referrals/DoLs received.
- The ORC team are supporting the development of a policy tool for patients and staff affected by gambling.

SECTION H
Safeguarding Team Development Plans 2023-24

8. MFT Safeguarding Team Development Plans 2023-2024

8.1 During 2023-24 the Trust will continue to develop safeguarding training, policy and practice to continuously improve support to staff, multi-agency colleagues and service users. The MFT 2023-24 safeguarding work plan, which will be implemented by all hospitals/MCS/LCOs, supported and monitored by the safeguarding teams, has the following objectives:

Figure 39: Trust Safeguarding Work Plan 2023-24 Objectives

1. **Making safeguarding personal (voice of the adult at risk), voice of the child.**
   A culture of listening and hearing the voice of children and adults at risk and their families, taking account of their wishes and feelings both in individual decisions and the development of services, with staff using professional curiosity in listening to people.
2. **Adult Safeguarding, keeping people safe.**
   Ensuring there are systems and processes in place to enable staff to recognise and respond to the needs of adults at risk to safeguard them from abuse and neglect.
3. **Safeguarding Children, keeping children safe.**
   Ensuring there are processes in place to ensure the needs of the child are prioritised and that the Trust and Hospitals/MCS/LCOs are committed to prioritising the protection of children in all work streams.
4. **Staff have access to supervision and support to safeguard vulnerable people.**
   To ensure staff are supported when dealing with difficult and complex safeguarding cases.
5. **Mandatory Adult and Children's Safeguarding Training.**
   To ensure we meet our statutory requirements and policy guidance requirements in safeguarding training
6. **All staff will be enabled to effectively safeguard, protect and promote the welfare, health and wellbeing of looked after children and young people and care leavers as outlined statutory guidance**[70].
7. **Application of Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS)/Liberty Protection Safeguards (LPS) is appropriate and proportionate across the Trust.**
8. **Raising Concerns/Managing Allegations for People in Positions of Trust working with unborn, children and families and adults at risk.**
   There is a culture whereby patients and relatives can raise concerns. Evidence of making safeguarding personal in all responses to concerns raised. If an allegation is made against a member of staff, all staff involved are aware of the processes to be followed.
9. **Complex and wider safeguarding**.
   Staff contribute to the wider safeguarding agenda and know how to escalate concerns in respect of responding to the needs of vulnerable groups.
10. **Safeguarding in the Context of a Citizen with Mental Health needs.**

[70] Statutory Guidance for Child Safeguarding Training is outlined in Section 11 of the Children Act 2004, and statutory guidance in Working Together 2018. Policy guidance for adult and children safeguarding training is identified in, Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff Adult Safeguarding: Roles and Competencies for Health Care Staff and Looked After Children: roles and responsibilities of healthcare staff (2020) and statutory guidance in Promoting the health and wellbeing of Looked After Children (2015)

There are systems and processes in place to enable staff to recognise and respond to the needs of people with; a mental health condition,

11. **Safeguarding in the Context of a Citizen with a Learning Disability and/or Autism.** There are systems and processes in place to enable staff to recognise and respond to the needs of people with; a mental health condition, a learning disability and/or autism
12. **Documentation. Accountable safeguarding documentation, enabling accessible information sharing in line with statutory requirements**
13. **Partnership Working/Information sharing.**
Staff work with other agencies to ensure the safety and protection of adults and children at risk.

8.2 This year the safeguarding team will continue to work with Manchester, Trafford and Greater Manchester Integrated Care Board safeguarding colleagues to strengthen safeguarding across the multi agency system.

8.3 The Trust will continue to support the safeguarding partnerships in the delivery of the revised safeguarding priorities. The Trust will support the implementation of the multi-agency learning from Manchester and Trafford Ofsted inspections[71] and contribute to Joint Targeted Inspections as required.

8.4 The safeguarding team will continue streamline safeguarding processes across the Trust footprint, whilst continuing to respond to local needs and risk.

8.5 Following the successful implementation of Hive, a key priority in our hospitals/MCS/LCO will be the optimisation of Hive and EMIS to support the delivery and documentation of statutory safeguarding processes across the Trust, including the development of a robust digital safeguarding assurance reporting framework .

8.6 Following the successful implementation of the revised mandatory safeguarding training in 2022/23, a revised training strategy will be launched this year and close scrutiny of the training accessed in all hospital/MCS/LCO will be required to ensure the Trust meets regulatory training requirements. A training strategy group will monitor mandatory training and lead the development of bespoke safeguarding training to meet the needs of frontline staff according to local need and risk.

8.7 Supporting the Trust to safeguard vulnerable groups including people with a learning disability and/or autism, people with mental health difficulties and looked after children remains a key priority for the Trust and reporting on the safeguarding activity to these groups will be strengthened, particularly focusing on patient experience and the voice of vulnerable people.

8.8 All safeguarding and specialist mental health and learning disability teams will focus on being visible and available to frontline services to promote, develop, support, monitor and review the highest quality safeguarding and care to all patients with a priority to reviewing and supporting the care of patients with a mental health condition, learning disability and/or autism and looked after children.

8.9 Each of the safeguarding teams has identified actions in support of the priorities set out in the Trust safeguarding workplan, which are summarised below:

[71] Manchester and Trafford Ofsted inspections

8.10 Midwifery Safeguarding NMGH, ORC and WTWA

Name of Team	Midwifery Safeguarding NMGH, ORC and WTWA
• Named Midwife/Matron for Safeguarding will meet with Head of Midwifery and Midwifery Matrons monthly to ensure that the Safeguarding Workplan is delivered and that any safeguarding incidents are discussed. Each clinical and ward area will be supported to have a Safeguarding Champion to promote the safeguarding agenda and update the safeguarding noticeboard including dissemination of the safeguarding newsletter. • To increase visibility and support to frontline services, safeguarding midwives will review all Hive admissions daily and conduct daily clinical and ward walkarounds. • A repeat audit to review delivery of ICON program will be completed in Q3. • With support from the Safeguarding Midwives team, the on-site IDVA will deliver bespoke domestic violence and abuse training for midwives to include completion of Domestic Abuse Stalking and Honour Based Violence Risk Indicator Checklist (DASH/RIC). • To support the full implementation of CP-IS.	

8.11 Manchester Safeguarding Children Community Team

Name of Team	Manchester Safeguarding Children Community Team
• To finalise the Standard Operating Procedure for the provision of safeguarding advice to GP practices within the city of Manchester. To continue to share learning from thematic review of consultations to strengthen practice and further develop understanding of roles and responsibilities. • To finalise the pathway for the management of bruising and injuries in non-mobile infants in consultation with community health services. To disseminate alongside accompanying learning slot to support practice. • A Named Nurse Safeguarding Children within the Manchester Community Safeguarding Team will be driving forward a workstream on safeguarding children with learning disabilities and conducting a SWOT analysis. • To map the safeguarding supervision offer for Trust wide CAMHS services to ensure this is equitable across the trust. • To finalise the Perplexing and Fabricated and Induced Illness pathway with MSP • To continue and complete the work of the strategy Task and Finish Group in order to improve standards across the partnership.	

8.12 Coral Suite Child Protection Team, Community Paediatrics and Trafford Community Named Doctor

Name of Team	Coral Suite Child Protection Team, Community Paediatrics
• MLCO will complete the RCPCH child protection delivery standards audit • MLCO Child Protection Coral Suite will host a visit from MFT's Chair • The child protection template for medical reports will be reviewed	

8.13 Trafford Community Children Safeguarding Team

Name of Team	Trafford Community Children Safeguarding Team
• Named Nurse Safeguarding Children to chair multiagency MARAC meetings on a quarterly basis • To support with the delivery of the TSSP multiagency training on Graded Care Profile and Impact Chronologies • To complete audits on safeguarding record keeping, domestic abuse and reaudit the use of the complex safeguarding risk indicator checklist • Continue to support TSSP with training events and multiagency work and audits. • To review the data collection tool for the Health Practitioner within Trafford First Response. • To continue to increase safeguarding team visibility within the Trafford Borough. • DASH/RIC Bespoke training to be delivered to the 0-19 service.	

8.14 Safeguarding Children NMGH, ORC and WTWA Teams

Name of Team	Safeguarding Children NMGH, ORC and WTWA Teams
• To review of Children and Young People in Crisis guidelines, in consultation with MSP and Take a Breath partnership work in line with learning from implementation in acute hospital settings. • In adult ED areas explore support required to Medical Teams to support a safeguarding response for 16 and 17 year olds. • Continue to develop closer working relationships and partnerships with Greater Manchester Mental Health Liaison Team (MHLT). • Review the assurance that CPIS is implemented across unscheduled and urgent care • Review and evaluate bespoke safeguarding training provision.	

8.15 Named Doctor Acute

Name of Team	Named Doctor Acute
• To continue to work with Hive team to develop processes within Hive to support safeguarding processes within MFT especially the child protection section 47 medical template.	

8.16 Adult Safeguarding NMGH, ORC and WTWA Teams

Name of Team	Adult Safeguarding NMGH, ORC and WTWA Teams
• To increase visibility and availability across the MFT footprint • The WTWA Safeguarding adults team plan to increase the visibility across community services to continue to provide safeguarding advice and support. • The ORC team will build excellent relationships with our senior colleagues within the CSU's, in particular the Eye and Dental Hospitals. The Named Practitioner at ORC will continues to build relationships with staff in our emergency department and other high-risk areas. • With LPS currently being indefinitely on hold the safeguarding team intend to build more confidence in use of the Mental Capacity Act and documentation of best interest decisions with commencement of a working party and inclusion of an audit around in the 2023-24 calendar.	

- ORC will improve the engagement and confidence of staff by implementing a new operational safeguarding approach; working alongside staff to complete safeguarding work. Currently the model is for the teams to guide staff through advice, however the intercollegiate document supports a flexible approach and so a “learn through observation” approach (watch one, learn one, teach one) will be adopted.
- To implement supervision with the Dental Hospital staff on a monthly basis.
- To speak to all trust conferences, ensuring that safeguarding is the golden thread which runs through the patient’s journey.
- NMGH safeguarding team aim to develop further assurances around lessons learnt from safeguarding enquiries and serious case reviews. Actions will include ensuring initial ‘lessons’ are cascaded/ put in place, but then follow up assurances to be gained that lessons are embedded.
- The safeguarding team will now attend the Manchester ‘Channel’ panel to ensure MFT’s contribution, where appropriate and build partnership working with Channel members to ensure the prevent programme remains highlighted by the safeguarding team to the wider MFT community.
- Managing Allegations Safeguarding Adults team plan to fully embed a robust managing allegations training for all line managers across the next 12 months to ensure new managers are fully aware of their responsibilities when concerns arise.

Safeguarding Audit Plan 2023-24

8.17 The audit plan aims to review how the Trust is meeting its statutory and regulatory responsibilities, evidencing delivery of safeguarding in MFT against the Greater Manchester (GM) Integrated Care Board Safeguarding Contractual Standards[72] and to demonstrate the implementation of learning following SAR/SCR/CSPR/DHR recommendations.

Figure 40: Trust Safeguarding Audit Plan summaries the 2023-24 safeguarding audit plan.

[72] Clinical Commissioning Groups Safeguarding Children, Young People and Adults at Risk Contractual Standards 2021-22 A Collaborative Greater Manchester (GM) Document The trust is required to submit evidence against 67 safeguarding stand+ards in APPENDIX 2: 2021-2022 - NHS PROVIDER SAFEGUARDING AND LOOKED AFTER CHILDREN AUDIT TOOL

Figure 40: Trust Safeguarding Audit Plan 2022/23

1. Safeguarding Children and the Unborn audits will review
   - Safeguarding Documentation
   - Safeguarding supervision
   - Application of child safeguarding policies including, child exploitation risk indicator checklist, safeguarding management of injuries in babies, children and young people medically fit for discharge but with no place to be discharged to guidance, child protection practice standards, child protection strategy meeting audit and safeguarding children and young people policy.
   - Implementation of learning from reviews including ICON programme to prevent abusive head trauma in babies and SCR U1 action plan
   - Review of safeguarding pathways including safe discharge for children subject to child protection plans and community domestic abuse pathways and health actions following domestic abuse multi agency risk assessment conferences.
2. Looked After Children (LAC) Audit will review
   - Review of health actions within and following health assessments including review of dental care and use of strengths and difficulties questionnaire.
   - Review of support to LAC placed with parents.
3. Safeguarding Adults and Vulnerable Groups audits will review
   - Application of the Mental Health and Mental Capacity Acts and DoLS process including an audit of advocacy process and application of patients rights.
   - Review of Adult Safeguarding policies including domestic violence and abuse risk assessments, prevention of missing patients, recognition and response to self neglect, and suicide prevention policy including the integrated care pathway for suicide and self-harm.
4. Generic Safeguarding Audits will include a review of the quality and dissemination of the safeguarding newsletter and review of application of Managing allegations policy.
5. Multi-agency audit as advised by Manchester and Trafford Safeguarding Partnerships including the annual Section 11 and the Adult Assurance audits.

Conclusion and Recommendations

8.18 Manchester continues to have one of the country's highest rates of deprivation, bringing with it a range of challenges for safeguarding. Trafford borough is a diverse area with areas of affluence and deprivation and with localised safeguarding needs and vulnerabilities. This annual report demonstrates the complexity of the safeguarding work undertaken within the Trust to ensure that patients, services users, and staff are safe.

8.19 Safeguarding is a key priority for the Trust, and this report provides assurance that the safeguarding team continue to deliver high volume and high-quality support to staff, to enable them to fulfil their safeguarding obligation and to enable the Trust to meet its statutory requirements.

The volume of safeguarding activity and the number of concerns reported by the workforce continue to increase year on year in the Trust with on average **95** safeguarding concerns reported by Trust staff every day (**84** in 2022/23).

8.20 A wide-reaching training programme has been developed and delivered to support the development of knowledge and skills across the workforce and, although improvement is still required to increase compliance with the revised "Think Family" mandatory safeguarding training programme at level 2 and 3.

8.21 The introduction of the Hive electronic patient record in the Trust has strengthened safeguarding documentation and reporting. The safeguarding alerts, assessments and flagging provide tools for the workforce to be professional curious and think safeguarding.

8.22 The MFT safeguarding service continues to ensure that the Trust remains sighted on and responds to legislative and practice changes that affect safeguarding. The expected implementation of the amendment to the Mental Capacity Act 2019 regarding introduction of Liberty Protection Safeguards has been delayed, enabling the Trust to refocus in 2023-24 on getting the basics right in practice in legal literacy and application of the Mental Capacity Act.

National reports[73] have highlighted the vulnerability of people with a mental health difficulties, learning disability and or autism in hospital care and the requirement of listening and hearing the patient voice. A scoping exercise of mental health provision against statutory and regulatory requirements has been completed and the new Mental Health Strategy will be launched in 2023. The implementation of the MFT Learning Disability Strategy has continued this year with a clear focus of the protecting patients' rights in providing individualised care and this has been supported through the Hive system. Next year the priority will be to implement a revised learning disability training offer in line with the mandatory training requirement in the Health and Care Act 2022[74]

8.23 In 2020 the Trust invested in a mental health and learning disability safeguarding team, this year has seen the impact of increased capacity and availability in the team to support the development of policy, guidance, training, support and advise to the workforce. In the appendices a separate report is provided on the specialist safeguarding teams' activity in supporting people with a mental health difficulty, a learning disability and or autism and looked after children.

8.24 This year the MFT safeguarding team ensured learning was shared and MFT contributed to the local response from national panel child safeguarding reviews[75] and

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[73] Services for autistic people and people with a learning disability **How we monitor the use of the Mental Health Act** https://www.cqc.org.uk/guidance-providers/autistic-people-learning-disability/right-support-right-care-right-culture

[74] The Oliver McGowan Mandatory Training on Learning Disability and Autism

[75] Child Safeguarding Practice Review Panel

national reviews including to contribution to the government consultation[76] in response to the Independent Review of Children's Social Care[77]. MFT will continue to contribute to the implementation plan following the consultation.

8.25 The "Think Family" approach continues to be promoted in MFT with the development of highly visible all age, integrated whole family safeguarding teams at NMGH, WTWA and ORC. The community teams continue to provide a localised response to our communities in Manchester and Trafford. In 2023-24 the safeguarding team will continue the integrated approach in supporting MFT safeguarding governance, policy, training and practice resulting in increased identification of safeguarding concerns and opportunities to reduce risks for our patients, however the teams will also focus on the safeguarding priorities in the localities in Manchester and Trafford providing an integrated safeguarding response throughout the person journey with MFT services.

8.26 Challenges continue to emerge that require a robust response with the further embedding of the complex and contextual safeguarding agenda including this year, learning about serious youth violence from safeguarding reviews as well as the need to prepare for future challenges and opportunities within the evolving health and social care landscape as the Integrated Care Board develops in GM. The safeguarding team will continue to support the Trust to embrace best practice, actively participate as a key multi-agency partner to deliver revised Manchester and Trafford Safeguarding Partnership priorities, but most importantly ensure that all patients and service users are afforded the best possible protection form abuse and neglect.

8.27 The safeguarding team will focus this year on assurance and impact to evidence that the Trust is achieving its safeguarding obligations and identifying the impact of the training programme and supervision through assurance visits, audit, delivery of the safeguarding workplan and development of reporting data sets using Hive

8.28 The Board of Directors is asked to note the extensive activity undertaken within the Trust and across the multi-agency partnership to support MFT staff and services to be responsive to the safeguarding needs of patients and service users. Members of the Board of Directors are asked to continue to support the Trust's on-going focus on safety, which ensures that safeguarding remains a key organisational priority.

[76] Stable Homes, Built of Love Implementation and Strategy and Consultation Children's Social Care Reform 2023

[77] Independent Review of Children's Social Care

SECTION I

Manchester Looked After Children and Trafford Children in Care Annual Reports 2022-23

Annual Report for the Looked After Children Health Service in Manchester 2022-2023

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Section 1: Introduction

Health and wellbeing of looked after children

1.1 It is recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and the blended effects of poverty, poor parenting, chaotic lifestyles, abuse, and neglect, looked after children often are at greater risk and have poorer health than their peers[78]. The Royal College of Paediatrics and Child Health (2020)[79] states that looked after children and young people have greater mental health problems, increased developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. They are more likely to be involved in risk taking behaviour, the youth justice system and have poorer educational attainment. Furthermore, the Department for Education and Department of Health (2015)[80] argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy, unhealthy lives as adults.

Definition of a looked after child

1.2 Under the Children Act 1989, a child is legally defined as 'looked after' by a local authority if he or she:

- Is provided with accommodation (by the Local Authority) for a continuous period of more than 24 hours
- Is subject to a care order; or
- Is subject to a placement order

A child that is being looked after by the Local Authority might be living with:

- foster parents
- at home with their parents under the supervision of children's social care
- in residential children's units
- other residential settings like schools or secure units

They might have been placed in care voluntarily by parents struggling to cope or children's social care may have intervened because a child was at significant risk of harm.

1.3 A looked after child ceases to be looked after when they turn 18 years old. On reaching their 18th birthday, the status of the child changes from being looked after to being a young adult eligible for help and assistance from the local authority, known as a Care Leaver.

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[78] Reference: Promoting the health and well-being of looked after children (2015) Department for Education and Department of Health (DFE, DH, 2015)

[79] State of Child Health Looked after Children

[80] Reference: Promoting the health and well-being of looked after children (2015) Department for Education and Department of Health.
Reference: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework (2020) Royal College of Paediatrics and Child Health

Such help and assistance is usually provided in accordance with the various aftercare provisions of The Children and Social Work Act (2017)[81].

Section 2: Purpose of the Report

2.1 The purpose of this report is to provide an overview of the progress, challenges, opportunities and future to support and improve the health and wellbeing of looked after children in Manchester. This includes all cohorts of looked after children for whom Manchester City Council is responsible, no matter where they are residing. This report covers the period 1st April 2022 to 31st March 2023. It summarises key improvements and service performance, along with setting out the objectives and priorities for the next financial year (2023-2024) for looked after children in Manchester.

2.2 Within all national and local policies and guidance, the service is known as looked after children. In Manchester the children and young people cared for by the local authority have been asked to be known as 'Our Children' in recognition of Manchester's corporate parenting responsibilities for this cohort of children and young people.

Manchester's Strategy for Our Children Young People and Corporate Parenting provides six key strategic priorities:

1. 'Our Promise to respect you and ensure you are happy'
2. 'Our Promise to help you be successful'
3. 'Our Promise to look after your physical and mental health'
4. 'Our Promise to make sure you are ready and kept safe'
5. 'Our Promise to care for you'
6. 'Our Promise to support you'

Section 3: National Policies and Legislation relevant to Looked After Children

3.1 The statutory guidance focused around looked after children is in abundance, the key documents and legislation are outlined as follows:

Children Act (1989, 2004)

Under this Act a child is defined as being 'looked after' by the local authority under the following four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents.
- **Section 31 and 38** children who are subject to an interim care order or care order.
- **Section 44 and 46** children who are subject to emergency orders.
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

Adoption and Children Act (2002)[82]

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

[81] Children and Social Work Act 2017
[82] Adoption and Children Act 2002

Care Matters: Time for Change (2007)[83]
This document sets out the steps to take to improve the outcomes of children and young people in care.

Children and Young People's Act (2008)[84]
The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care services which are focused on and tailored to their needs.

Children and Families Act (2014)[85]
This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs.

Promoting the Health and Wellbeing of Looked After Children (2015)
This guidance was issued by the Department of Health and Education. It is published for Local Authorities, Clinical Commissioning Groups, Service Providers and NHS England.

The Children and Social Work Act (2017)
The Act is intended to improve support for looked after children and care leavers, promote the welfare and safeguarding of children and make provisions about the regulation of social workers.

Looked After Children: Knowledge, skills, and competencies of health care staff, Intercollegiate Framework (2020)
This document sets out specific knowledge, skills and competencies for professionals working in dedicated roles for looked after children.

Looked-After Children and Young People. NICE Guideline (2021)
This guideline covers how organisations, practitioners and carers should work together to deliver high-quality care, stable placements and nurturing relationships for looked-after children and young people. It aims to help these children and young people reach their full potential and have the same opportunities as their peers.

Section 4: National and Local Context

4.1 Nationally the number of looked after children has increased steadily over the past 10 years. There were **82,170** looked after children on 31st March 2022, an increase of 2% compared to 31st March 2021 which is a continued increase compared to the previous year's data. The most up to date national figures for 2022/2023 are not yet available from the Department for Education, the usual annual publication date being December. **Figures 1 to 3**, below set out the national and local position.

[83] Care Matters: Time for Change (2007)
[84] Children and Young Persons Act 2008
[85] Children and Families Act 2014

4.2 **Figure 1: Number of children looked after in England at 31st March 2015 to 31st March 2022**

Year	Number	Rate per 10,000 child population
2015	69,470	60
2016	70,410	60
2017	72,610	62
2018	75,370	64
2019	78,150	65
2020	80,080	67
2021	80,850	67
2022	82,170	70

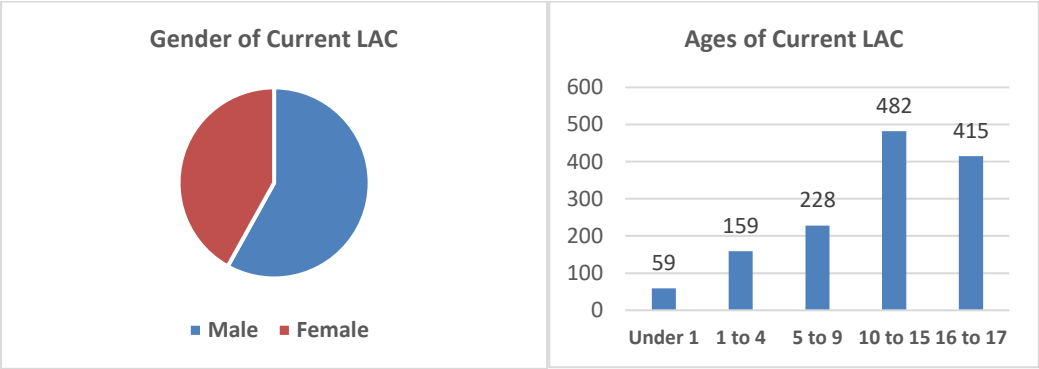
Ref: Data made available from Department for Education publications

4.3 **Figure 2: Number of children looked after in North West England and Manchester at 31st March 2015 to 31st March 2023**

Year	North West		Manchester	
	Number	**Rate per 10,000 child population**	**Number**	**Rate per 10,000 child population**
2015	12,490	82	1,310	114
2016	12,550	82	1,252	107
2017	13,220	86	1,169	97
2018	14,050	91	1,258	104
2019	14,660	94	1,290	106
2020	15,130	97	1,407	114
2021	15,260	97	1,371	111
2022	15,210	97	1,385	111
2023			1,343	109

Ref: Data made available from Department for Education publications and Manchester City Council

4.4 **Figure 3: Profile of Looked After Children in Manchester**



4.5 The numbers of children in the care of Manchester City Council (MCC) at the end of 2022/2023 has remained relatively stable, which differs to the national picture where there continues to be an increase. Manchester continues to have a significantly higher proportion of looked after children per 10,000 child population compared to the England profiles. Manchester has the twenty-fifth highest population of looked after children nationally, Blackpool has the highest rate at 218 LAC per 10,000 children and Merton (London) has the lowest at 26 LAC per 10,000 children.

Section 5: Commissioning Arrangements

5.1 Looked After Children's access to health services is underpinned by a complex set of commissioning arrangements within the responsible commissioner guidance (2013)[86]. The guidance advises that the child's registered GP at the point of placement determines the responsible Clinical Commissioning Group (CCG) for the cost of any health services in addition to universal services. This includes services provided through its commissioned services such as CAMHS or community paediatrics as well as for routine health assessments. Currently there is an agreement within the Greater Manchester health economies that there is no cross charging for health assessments. Integrated care boards (ICBs) replaced clinical commissioning groups (CCGs) in the NHS in England from 1 July 2022. As such, the commissioning model for specialised services will evolve in the coming years due to this. The responsible commissioner guidance was updated in June 2022 to reflect this change (2022) [4A] Close partnership working with the Designated Team in the ICB is pivotal to ensuring positive health outcomes for our children.

5.2 Manchester Integrated Care Board (ICB) currently commission the Manchester University NHS Foundation Trust (MFT) Looked After Children's health team ensuring the health needs of Manchester's looked after children, young people and care leavers are met in line with national guidance and local service specification. Manchester Local Care Organisation (MLCO) are commissioned to meet the health needs of looked after children within the health visiting and school health services, which includes undertaking review health assessments and liaising with all relevant agencies to support and promote their health and wellbeing. The completion of initial health assessments is included within this commissioning arrangement.

Section 6: Key Performance Indicators

6.1 The work undertaken by the health team is underpinned by statutory requirements against which performance is monitored by the Trust and reported to Manchester Integrated Care Board.

6.2 Statutory guidance set out in Care Planning, Placement and Case Review (England)[87] Regulations (2015) states:

[86] Ref: Who pays? Determining responsibility for payments for providers: Rules and Guidance for CCG's: NHS Commissioning Board (2013)
[4A] Ref: Who Pays? Determining which NHS commissioner is responsible for commissioning healthcare services and making payments to providers. Version 2 (2022)
[87] Reference: Children Act 1989 guidance and regulations volume 2: care planning, placement, and case review (2015) Department for Education

- Local Authorities (LA) must arrange for all Looked After Children to have a health assessment
- The initial health assessment (IHA) must be undertaken by a registered medical practitioner
- The IHA should result in a health plan, which should be available in time for the first statutory review of the child's care plan by the Independent Reviewing Officer (IRO)
- The case review by the IRO must happen within 20 working days from when the child became looked after (Regulation33(1))
- A health review should be undertaken at least once in every period of 6 months before the child's fifth birthday and at least once in every period of 12 months after the child's fifth birthday.

6.3 The Key Performance Indicators (KPI) as set within the Service Specification for Specialist Looked After Children Health Services are identified below.

Figure 4: Key Performance Indicators

Our Children	KPI
% of Initial Health Assessments within Statutory Timescales	90%
% of Review Health Assessments within Statutory Timescales	95%
% Immunisation Status	90%
% Dental Attendance	95%
% SDQ's available to inform Review Health Assessment	85%
% of young people leaving care in receipt of a Care Leaver Health Summary	80%
% of children with up to date Health Surveillance Check	95%
% BMI's recorded	95%
% of Health Assessments containing voice of the child	95%

Section 7: Manchester Looked After Children's Health Team

7.1 The health team provide a citywide health service for looked after children placed in Manchester by Manchester City Council and children looked after from other local authority areas placed in Manchester. They also retain oversight responsibility for Manchester children and young people residing in other local authority areas. This is achieved by close working relationships with the looked after children's health teams in that local authority areas and a robust oversight process within the health team.

7.2 As Manchester has higher numbers of looked after children compared with national figures, this places significant pressures on the health team, but also on colleagues in the Manchester Local Care Organisation (MLCO), paediatricians, health visitors and school nurses in ensuring the statutory health needs of these children are met. The increasing numbers also impact primary care services namely General Practices (GPs) and dental services.

7.3 MFT is commissioned to provide initial health assessments (IHA) and review health assessments (RHA) for Manchester children placed in Manchester and for children from other local authority areas placed in Manchester.

Unaccompanied Asylum-Seeking Children (UASC)

7.4 UASC are under 18 years and are likely to become looked after because they are without accommodation, separated from parents and are not being cared for by an adult who by law has responsibility to do so. Under section 20 of the Children Act 1989, local authorities are under statutory obligation to provide accommodation for unaccompanied asylum-seeking children who present in their area. This means that they become looked after and should be safeguarded and have their welfare promoted in the same way as any other looked after child/young person. The health team has 0.8WTE dedicated UASC specialist nurse capacity to support the health needs of the UASC population in Manchester ensuring the best possible health outcomes for this cohort of young people. All the specialist nurses within the team have UASC on their individual caseloads to ensure that they obtain the skills and experience in supporting this cohort of young people. The UASC specialist nurse continues to provide oversight and support to the specialist nurses.

7.5 Nationally the numbers of UASC have increased to **5570** at the end of March 2022 (25% rise from the previous year). The numbers of UASC in Manchester have also significantly increased compared to the previous reporting period. There are currently **175** UASC who are the responsibility of Manchester City Council which equates to approximately **13%** of the looked after population and indicates similarity to the national picture, a **28%** increase in cohort from the previous year. Economic and political issues affecting countries across the world have contributed to the increase.

7.6 At the time of writing this report, the majority of the UASC cohort remain male with only **7** being female. The majority of the UASC supported by MCC are placed in Manchester (**113/175** 65%). The ages range from 13 years to 18 years with a high proportion continuing to be in the 17 years age bracket (66%). The highest number of young people originate from the Afghanistan (29%), second highest from Sudan (26%). The number of young people from Afghanistan has increased since last quarter and is a probable reflection of the continuing conflict in that area. There is representation from 17 other countries including, Eritrea (x18) and Iran (x11). Most of the young people are residing in semi-independent living accommodation (62%) with the remainder either living independently (14%) or with foster carers (24%).

7.7 The UASC specialist nurse and looked after children nursing team continue to have strong relationships with the New Arrivals Team within Manchester City Council providing valuable health support to the social workers and to the young people.

7.8 Effective partnership working between the looked after children health team and the Named and Designated Doctors for looked after children to achieve improved outcomes for UASC continues. A poster presentation on UASC has been generated jointly and is to be displayed at a Royal College of Paediatrics and Child Health (RCPCH) event.

Care Leavers

7.9 A Care Leaver is an adult who has spent time in care as a child, such as foster care, living with family or in a residential care setting. Their time in care could have lasted for a few months or from birth until their 18th birthday. All young people who leave care at 16, 17 or 18 years of age are statutorily provided with support from the local authority in the area in which they live.

7.10 Statutory Guidance on Promoting the Health and Well-Being of Looked After Children (2015)[88] requires local authorities, Integrated Care Boards and NHS England to ensure that there are effective plans in place to enable looked after children aged 16-17 years to make a smooth transition to adulthood. This includes providing them with as much detail as possible on their health history including birth details. Care leavers should expect the same level of care and support that other young people get from their parent. Young people looked after by Manchester City Council are provided with a summary of their health history prior to their 18th birthday.

7.11 The introduction of the Children and Social Work Act 2017[89] ensures that all local authorities provide a local offer for care leavers including the provision of a personal advisor up to the age of 25 years. This has been reflected within the health team whereby they continue to support care leavers through advice and consultation during their transition into adulthood.

7.12 The health team has established strong relationships with the local authority Leaving Care Team to ensure that the health needs of care leavers are being supported. The health team provide a 'drop-in' service for care leavers and Personal Advisors which further enhances this support. The health team also provide support for care leavers via the duty nurse contact.

MFT Looked After Children Nursing Team

7.13 **Key Achievements**

- ✓ Stability within the looked after children health team, with the team working well together in a supportive and positive environment.
- ✓ Partnership working with Manchester City Council Children's Services to identify and improve health outcomes for looked after children.
- ✓ Partnership working with the New Arrivals Team to improve health outcomes for UASC.
- ✓ Strong relationships with universal services within Manchester Local Care Organisation by providing support to health visitors and school nurses through attendance at team meetings and training.
- ✓ Continued implementation of the Combined Consent Form incorporating consent to placement, medical treatment, health assessments and information sharing with Manchester City Council Children's Services.
- ✓ Joint development and implementation of escalation pathway for IHA and RHA processes with the local authority
- ✓ Maintained robust oversight of the health needs of looked after children residing out of the Manchester area.
- ✓ Delivery of training programme for MFT staff in acute and community settings.
- ✓ Improved relationships with the residential settings across Manchester, due to locality-based working within the specialist nursing team.
- ✓ Continued implementation of 'Multi-Agency Guidance on the Strengths and Difficulties Questionnaire for Manchester' Looked After Children'.
- ✓ Attendance at the Corporate Parenting Cooperative to seek the voice of the child.
- ✓ Triangulation of dental data between health and social care to improve reporting

[88] Promoting the health and well being of looked after children.
[89] Children and Social Work Act 2017

7.14 **Challenges**

- The reporting systems required to support the data collection from the electronic patient record (EMIS) have not been fully utilised by health practitioners to enable reporting of the work undertaken.
- Delay in receiving information from the local authority impacting timeliness of IHA and RHA completion within statutory timescales.

Paediatric Looked After Children Service

7.15 **Key Achievements**

- ✓ Continued liaison with CAMHS-LAC team and LAC Specialist Nurses team to enable appropriate support for those with emotional health difficulties and care leavers.
- ✓ Successful implementation of UASC IHA report template adapted from the Kent model
- ✓ Adaptation of Moods & Feelings questionnaire so it can be embedded within IHA template
- ✓ Completed audit of health needs of UASC and service provided by specialist nurses – which has been accepted for national presentation at RCPCH conference 2023
- ✓ Service development engagement initiative to establish young people's views on their health assessments and incorporated this feedback into future service plans.
- ✓ Good practice cases identified within service – a child with Deprivation of Liberty Safeguards identified during IHA related visit and concerns escalated promptly leading to Rapid Review with responsible LA.

7.15 **Challenges**

- Delay in receiving notification from the local authority of a child becoming looked after and receiving correct documentation prior to IHA taking place. There is continued joint work on processes and communication with the local authority.
- Difficulties with interpretation service. The paediatric team are still coordinating IHA appointments with face-to-face interpretation whenever possible, ongoing work with service to avoid delayed or cancelled appointments for unaccompanied asylum-seeking children and young people.

7.16 **Development Plan for 2023/2024**

- Update IHA guidelines and IHA report/plan templates
- Revise IHA decliner pathway
- Complete audit following up IHA actions
- Joint working with New Arrivals Team to agree processes for UASC
- Update guidelines for bloodborne infection testing for children in care
- Participate in multi-agency audit on Looked After Children who have Education Health Care Plans
- Re-establish peer review meetings with health partners
- Progress service development engagement initiative to establish young people's views on their initial health assessments and incorporate their feedback into future service plans.

Section 8: Performance

Figure 5: Performance against Key Indicators

Our Children	KPI	Q1	Q2	Q3	Q4
% of Initial Health Assessments within Statutory Timescales	90%	**52%**	**71%**	**42%**	**48%**
% of Review Health Assessments within Statutory Timescales	95%	**82%**	**86%**	**82%**	**88%**
% Immunisation Status	90%	**87%**	**90%**	**86%**	**87%**
% Dental Attendance	95%	**36%**	**35%**	**49%**	**58%**
% SDQ's available to inform Review Health Assessment	85%	**46%**	**59%**	**34%**	**34%**
% of young people leaving care in receipt of a Care Leaver Health Summary	80%	**33** shared	**32** shared	**38** shared	**40** shared
% up to date Health Surveillance Check	95%	**98%**	**99%**	**100%**	**100%**
% BMI's recorded	95%	**93%**	**96%**	**94%**	**98%**
% of Health Assessments that contain the Voice of the Child	95%	**99%**	**99%**	**100%**	**100%**

8.1 **Initial Health Assessments**

In 2022-23 there has been intensive joint working between the MFT LAC health team and Manchester City Council to improve LAC IHA performance, this has not resulted in improvement in the completion of initial health assessments within the statutory timescales of 20 working days from entering care. **40%** (180/449) of children and young people entering care during 2022/2023 had their initial health assessment completed within the statutory timescale, which is lower than the previous year.

8.2 Many of the breaches have remained attributed to the delays in the receipt of a consent and request form from the local authority. A combined consent was developed and implemented in October 2021 which integrates previous consents to placement, medical treatment, health assessments and information sharing. The combined consent is a paper consent which requires the signature of birth parents, or person with parental responsibility, the consent is then uploaded onto Manchester City Council's Liquid Logic system to be shared with the health team. There was a significant (43%) increase in the numbers of children and young people entering care in Manchester within quarter 4 which will have also contributed to additional pressures on looked after children health services. Whilst compliance remains outside its performance indicator, there have been some improvements during the latter end of the reporting period. Performance continues to be reviewed monthly by both partners to further develop an understanding of the delays.

8.3 Compliance for LAC residing out of the Manchester area remains particularly poor which is mainly attributed to the delays in obtaining the consent and request form but is also due to the appointment availability in the host area. This has been reviewed with the Designated LAC team at Manchester Integrated Care Board and work will continue in the next reporting period to address this issue.

8.4 **Review Health Assessments**

Compliance of review health assessments completed within the statutory timescales has been consistently outside of the performance indicator but has shown improvement from the previous year. Delays in obtaining consents and request documentation from the local authority particularly for the children and young people residing out of the Manchester area has continued to be a primary factor throughout the year. There have also been continued issues of staffing capacity within the Health Visiting and School Nursing Service as well as within the Specialist Nursing Team which have affected timeliness. Whilst it can be assured that the health assessments are being completed this may not always be within the statutory timescales.

8.5 An alert system within Manchester City Council's Liquid Logic system was introduced to act as a reminder for the social worker that a review health assessment is due and to initiate the correct documentation. Requests and consents are now being received by the health team through the Liquid Logic system instead of via the secure email which has streamlined processes.

8.6 Review health assessments for children and young people residing out of area continues to be a concern, with continued delays in the receipt of requests and consents from the local authority. The new combined consent form used at the initial health assessment also includes an 'enduring consent' for the completion of health assessments for the duration that the child/young person is in care which has the potential to reduce the delays in the receipt from the local authority.

8.7 **Immunisations**

Immunisation compliance has shown improvement during 2022-2023 from the previous year. The looked after children health team continue to undertake a validation exercise each quarter of GP immunisation records to identify children and young people who have received their immunisations but where it has not been updated within the reporting system. There continues to be challenges in the agreement of the Looked After Children Specialist Nurses administering the immunisation programme for the 16+ years age group and discussions remain ongoing. The Specialist Nurses are following up and encouraging carers and young people with outstanding immunisations to access their GP. It remains a concern that compliance in Manchester is below the Northwest and England profile. The Named Nurse LAC continues to with Public Health and Manchester Integrated Care Board to identify and implement solutions to improve the compliance.

8.8 **Dental Attendance**

Dental attendance data has improved this year. The Greater Manchester Escalation Pathway was developed during the previous year and has continued to enable practitioners to refer children and young people to a central referral hub for review and allocation to a specified dental practice. This has shown a positive improvement in dental attendance although this is not reflected within the data. It is understood that the apparent reduction in compliance may be due to the ability to record the information in a timely manner onto the reporting system. Triangulation of the data has been undertaken between health and the local authority each month to ensure that both reporting systems have the most up to date information. Dental data from both agencies is cross referenced to achieve a combined report with each agency being responsible for ensuring they update their own electronic child/young person's record.

8.9 **Strengths and Difficulties Questionnaire (SDQ's)**

The SDQ is a tool that is used to screen for any problems related to a child/young person's emotional well-being. Receipt of SDQ's to inform the review health assessment has remained a challenge throughout the reporting period, however intensive collaborative working between the local authority and the health team has resulted in an improvement in the compliance towards the end of the period. The 'Multi-Agency Guidance on the Strengths and Difficulties Questionnaire' was revised and has been implemented within partner agencies to support the new processes.

8.11 Trauma informed practice is promoted across the MFT training programmes for looked after children and is inherently present within the roles of the specialist nursing team. Nationally, the most common reason for a child to enter care is as a result of or because they were at risk of abuse or neglect – (54,270 children-66%). Work will continue to be completed with partner agencies to ensure health professionals are capturing and responding appropriately to the emotional health and wellbeing needs of looked after children.

8.12 **Care Leaver Health Summary**

A care leaver health summary has been shared with young people in Manchester since its recommendation in statutory guidance in 2015. Whilst it has remained difficult to obtain the percentage of Care Leavers who have received a health summary due to the challenges in the implementation of the reporting template, **137** health summaries have been shared with young people during this reporting period. This is one more health summary than were shared last year. Revised processes and a more robust communication pathway have been established between the health team and the Leaving Care Team to ensure that all young people including those who reside out of the Manchester receive their health summary to ensure they are informed of their health needs as they transition into adulthood. A monthly drop in has been established at The Beehive predominantly for the Leaving Care Personal Advisors/Workers but also for young people should they wish to attend. The drop-in sessions have continued to assist in strengthening relationships between the health team and the Leaving Care Team with dedicated space being provided to the health team for health promotion.

8.13 **Health Surveillance Check**

Health surveillance checks in line with the national Healthy Child Programme are being undertaken at the relevant ages and stage of development.

8.14 **BMIs**

Tackling obesity is one of the greatest long-term health challenges currently faced in England. In England 1 in 3 children leaving primary school are overweight or living with obesity and obesity prevalence is highest amongst the most deprived groups in society [8]. The number of children and young people identified as having a higher-than-normal BMI continues to increase for Our Children particularly for those residing in the Manchester area. The health team will respond to this in partnership with other agencies across the city. The cost-of-living crisis has impacted families, carers and young people on the choices they make regarding nutrition, access to transport and access to physical activity. Access to leisure facilities across Manchester was a key action completed from the LAC Children's Health Network this year.

The health team will continue to review the BMI's and explore the support that children, young people, and carers require to achieve a healthy weight.

8.15 **Voice of the Child**

The voice of the child is paramount throughout all work with children and young people and should be accurately reflected within any contact that is undertaken with them. Health assessments are key milestones within a looked after child's journey through the care system and it should provide the opportunity for them to confidently share/voice their wishes and feelings. The voice of the child has continued to be positively captured throughout this reporting period through their health assessments.

8.16 It is vital that as corporate parents MFT promote health professionals to work together with children to achieve their personal aspirations. During health assessments children and young people have told us; 'I would like to go to university', 'I would like to become an interpreter to help people in hospital', 'I want to go into the building trade, like my dad and brother', 'I want to be a professional footballer'. The health team acknowledge individual ambitions and promote positive outcomes for each child.

Section 9: Governance

9.1 A partnership approach is essential to ensuring best outcomes for children and young People, with the LAC health team working closely with Manchester City Council colleagues to ensure they have the correct information in a timely manner to provide a robust health offer. Escalation processes are also agreed and in place between MFT and MCC to address issues as they arise to ensure a timely response and improve service provision.

9.2 **Engagement**

The health team attended and contributed to LAC Cooperative Sessions arranged by MCC Corporate Parenting Cooperative. These sessions were an opportunity to meet children and young people and obtain their voice based on the key strategic priorities set out in the 'Manchester's Strategy for Our Children Young People and Corporate Parenting'. The health team have undertaken consultations with the UASC population to review and improve service provision. The results of which have been accepted for display at an RCPCH event this coming year.

9.8 **Audit and review**

There is a robust audit plan in place which will focus on health outcomes for looked after children. This year the audits undertaken were to review of the health care plans for children placed out of area, and the availability and use of the strengths and difficulties questionnaire at the time of review health assessment.

Section 10: Objectives and Priorities for 2023/2024

10.1 **Objectives**

- Continue to raise awareness of the specialist nursing service across the Trust to develop pathways for coordinated care
- Continue to monitor and analyse the health assessment data to identify evolving solutions to the delays in timely compliance.

- Engage in consultations with children and young people to continue to improve services and outcomes.
- Revise the current training package (to include an online learning option) for professionals to inform them of the health needs of looked after children, their journey throughout the looked after process and the professionals' roles and responsibilities in achieving the best outcomes.
- Establish robust reporting and collation of data from the electronic patient record to support service development
- Work in partnership with the local authority to ensure continued positive transference of information between the two agencies
- Undertake a further review of immunisation coverage for looked after children with a view to increasing performance with Public Health and ICB.
- Continued liaison with ICB and the Greater Manchester Dental Partnership to ensure that dental services are easily and readily accessible for our children and young people
- Undertake relevant and appropriate audits to ensure that Our Children receive positive health outcomes during their looked after journey

Section 11: Conclusion

11.1 The LAC health team have found some stability at the end of the year as a result of successful recruitment and retention within the team. This has had a positive impact on the team's ability to meet the statutory requirements for looked after children and young people and provide additional support to residential settings across the city.

11.2 2022-2023 has seen some improvements to performance and ultimately health outcomes for children and young people. However, these have not been consistent in meeting national key performance indicator thresholds for our most vulnerable children and young people. Achieving positive health outcomes for all Our Children and Young People regardless of where they reside is the priority for the health team with a focus on gaining a deeper understanding of the barriers to overcome them.

Annual Report for the Looked after Children (Children in Care) Health Service in Trafford 2022-2023

Completed by:
Catherine Hough Named Nurse Safeguarding Children, Children in Care and Adult Strategic MFT Trafford Safeguarding Team

Section 1: National and Local Context

Figure 1: Number and rate of children looked after in Trafford from 31st March 2015 to 31st March 2021

Year	Trafford	
	Number	Rate per 10,000 child population
2015	334	62
2016	331	61
2017	384	70
2018	383	69
2019	417	74
2020	378	67
2021	392	69
2022	359	66

Ref: Data made available from Department for Education

1.1 Nationally, the number of Looked after Children has continued to rise. At 31st March 2022, the total number of Looked after Children (LAC) by Local Authorities (LAs) in England increased by 2% to **82,170**. Data provided by Trafford local authority (LA) has demonstrated that the numbers of Looked after Children has slightly increased during the past twelve months. Local data shows a reduction in the number of Looked after Children in April 2022 as **359** (66 per 10,000 children), which is lower than the national average.

1.2 Children can be placed in foster care (placed with the local authority or independent agency foster carers), or in a connected person (family or friends) placements. These places are all vetted. Some young people live in supported accommodation or move to independent living. Other arrangements are put in place for children with more complex needs. A small number of children live in secure settings.

Section 2: Trafford Looked After Children Health Service

2.1 The MFT Looked After Children Health Team ensures that the health needs of Trafford's Looked after Children and Care Leavers are met in line with national guidance and the local service specification. In Trafford, the Local Authority (LA) use the terminology 'Cared for and care experienced children and young people'. For the purposes of this report for MFT the term Looked after Children is used for consistency in the wider Trust report. The service specification for the Looked after Children Health Team incorporates responsibility for:

- Children and young people (aged 0-18) who are looked after by Trafford and placed in borough
- Children and young people (aged 0-18) who are looked after by another LA, but reside in borough
- Trafford LA children (aged 0-18) placed out of borough
- Open access to care leavers from 16 up to age 21 who are living within the borough

2.2 **Overview of the Service**

The Trafford Looked after Children Health Team comprises of:

- Named Nurse Safeguarding Children/ Looked after Children
- Named Doctor Looked after Children
- Senior Specialist Nurse Looked after Children / Team Leader
- Specialist Looked after Children Nurses
- Administrative Assistants

2.3 The Team works closely with Trafford Local Care Organisation (TLCO) colleagues including the 0-19 Service, which is commissioned to provide the universal child health programme to Looked after Children. The TLCO Paediatric Team provide initial health assessments (IHAs) for all Looked after Children residing in Trafford when they enter care. Review health assessments (RHAs) for children who are under 5 years of age are undertaken by the Trafford health visitors. The Looked after Children Specialist Nursing Team complete the RHA's for school age children and those young people who are aged 16 years and over. Trafford has many Looked after Children resident in the borough from other LA's. Requests from other LA's for RHA's for school aged children placed in Trafford are completed by the child's school nurse (SN) with the Looked after Children Health Team available to provide specialist support to them where required. Many of these children are placed away from their LA due to being at risk of exploitation and/or because they have complex needs that require specialist provision.

2.4 The Looked after Children Health Team is part of the wider looked after children multi-agency service within Trafford. Health and social care colleagues are co-located, which strengthens multi-agency working and facilitates a more coordinated approach to meeting the health needs of our children and young people. The Named Nurse and Senior Specialist Nurse meet regularly with the social care service managers, the Virtual School, Children's Advocacy service, and the principle psychologist for Trafford 'Child and Adolescent Mental Health Service' (CAMHS) for Children in Care service. The health team work closely with the Designated Nurse for Safeguarding and looked after children within Trafford Integrated Care Board (ICB) who provides strategic oversight.

Unaccompanied Asylum Seekers (UASC)

2.5 UASC are children and young people under the age of 18 years who have applied for asylum in the UK without their parents and are not being cared for by an adult who by law has responsibility to do so. Under section 20 of the Children Act 1989, LA's have had a statutory obligation to provide accommodation for UASC who present in their area. These children should be safeguarded and have their welfare promoted in the same way as any other Looked after Child/Young Person. Many of these children will have lived through trauma and/or stressful circumstances and often present with a variety of complex physical and emotional health needs, which means that they are more likely to require specialist care. At the end of March 2023 there were **56** children/young people who entered care as UASC residing in Trafford. **16** of these are looked after by Trafford LA with the remainder placed by other LA's.
The Looked After Children Health Team promote effective provision and oversight of health services and support for UASC in Trafford regardless of the placing borough.

Care Leavers

2.6 A Care Leaver is an adult who has spent time in care as a child. Statutory Guidance on Promoting the Health and Well-Being of Looked after Children (2015) requires LA's, ICBs and NHS England to ensure that there are effective plans in place to enable Looked after Children aged 16-17 years to make a smooth transition to adulthood. This includes providing them with as much detail as possible of their health history including birth details. The introduction of the Children and Social Work Act 2017 states that all LA's must provide a local offer for care leavers including the provision of a 'personal advisor' up to the age of 25 years. The Looked after Children Health Team currently provide support to care leavers, through consultation with their 'personal advisor' in respect of complex health issues.

Section 3: Looked After Children Nursing Team

3.1 **Key Achievements 2022/2023**

- ✓ A Standard Operating Procedure to enable the Looked After Children Health Team to immunise within a legal and safe framework has been developed. This will enable the Looked After Children Health Team to offer a targeted domiciliary immunisation service to Looked After Children.
- ✓ Close working relationship with the Designated Doctor for Looked After Children and Designated Nurse for Safeguarding Children/ Looked After Children in Trafford has been developed.
- ✓ Looked After Children Health Team have completed bespoke training sessions on health assessments for looked after children with the 0-19 service, initially focusing on Health Visitors which is linked into themes emerging from quality assuring the assessments and reinforcing trauma informed practice.
- ✓ Looked After Children Health Team meetings are now including practice development sessions that incorporate discussions on children/ young people to ensure a refocus on greater awareness of health needs and refocus the caseload into their team meetings.
- ✓ Named Nurse Safeguarding Children/ Looked After Children has commenced attending local authority Permanence Panel meetings.
- ✓ Drop-in sessions in the residential care settings have re-commenced by the Looked After Health Team on a weekly basis.

Challenges

3.2 Children and young people have presented for health assessments without completed signed consent forms which has caused delay in assessments being completed in timescales. The Named Nurse Safeguarding Children/ Looked After Children has been and is continuing to work with Trafford Local Authority to review the current process and historic arrangements that were in place between health and social care, to ensure consent forms are available prior to appointments.

Section 4: Paediatric looked after children Service

4.1 **Key Achievements 2022/2023**

- ✓ Named Doctor for Looked After Children commenced in post in March 2023.

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Challenges

4.2 The Named Doctor – Looked After Children post within the Trafford Community Paediatric Team has remained vacant until March 2023 which has impacted service development for looked after children in Trafford. Locum cover was in place to support timely completion of IHA's.

4.3 **Development Plans for 2022/2023**

- ✓ The Request for Health Assessment Pathway incorporating the requirement for signed consent to be finalised and embedded to support and enable timely health assessments.
- ✓ For the Standard Operating Procedure to be ratified to enable the Looked after Children Health Team to immunise within a legal and safe framework to complete the ratification process in MFT.
- ✓ For Children in Care Health Team to complete immunisation training in preparation for undertaking opportunistic immunisations with a focus on 16/17 year olds.
- ✓ To continue to utilise live data from the local authority to support planning, implementation and service delivery to meet the health needs of Looked After Children in Trafford.

Section 5: Performance

Figure 2: Performance measures for the MFT CIC Health Service for 2022/2023.

Our CIC	KPI	Q1	Q2	Q3	Q4
% of Initial Health Assessments within Statutory Timescales	90%	64% 14 out of 22	62% 8 out of 13	36% 12 out of 33	18.1% 6 out of 33
% of Initial Health Assessments within 20 working days of receipt of information	90%	68% 15 out of 22	69% 9 out of 13	42% 14 out of 33	24.2% 8 out of 33
% of Review Health Assessments within Statutory Timescales under 5 years	90%	83% 25 out of 30	89% 24 out of 27	93% 25 out of 27	90% 35 out of 39
% of Review Health Assessments within Statutory Timescales over 5 years	90%	84% 220 out of 262	83% 204 out of 245	83% 204 out of 245	86% 195 out of 228
% Immunisation Status		89% 261 out of 292	88% 238 out of 272	85% 217 out of 255	34.8% 93 out of 267
% Dental Attendance		55% 162 out of 292		38% 98 out of 255	60% 160 out of 267

5.1 The work undertaken by the Trafford Looked After Children Health Team is underpinned by the statutory requirements for looked after children, against which performance is monitored by the Trust and reported to Trafford ICB Designated Nurse Safeguarding Children and Looked After Children monthly. The table above shows performance measures for the MFT Looked after Children Health Service for 2022/2023.

Initial Health Assessments

5.2 Statutory guidance requires a registered medical practitioner to carry out an IHA of a child's health and to provide a written report of the assessment, which should result in a health care plan being available for the child's first statutory review, which must happen within 20 working days from when the child entered the care of the LA. The TLCO Paediatric Team is commissioned to complete IHA's for all looked after children placed in Trafford.

5.3 Compliance with completion of IHA's within statutory timeframes has declined over the year. Many IHA's not completed within timescale were as a result of delayed notifications of children and young people entering care via Trafford Council's Liquid Logic system along with delay in obtaining signed consent for health assessments.

5.4 For children placed out of borough, the assessments are completed by out of area paediatric teams. The expectations of information required prior to completion of assessments can vary across boroughs: this has also impacted on timescales. Most often this relates to a request for a LA to obtain written consent for a health assessment. All delayed assessments for children residing out of borough are actively followed up by the Looked After Children Health Team. Work is ongoing with the LA to address how access to written consent can be obtained.

5.5 Whilst most appointments are clinic-based, the team has worked flexibly to accommodate the individual needs of our looked after children, including assessing children and young people out of clinic, where other settings are better equipped to meet their needs. The team liaises with social workers, parents, carers, and young people to facilitate appointments and support with transport arrangements.

5.6 Work is ongoing with the LA to ensure that the timeliness of alerting the Looked After Children Health Team of a child entering care is prompt allowing for the statutory timescale for IHA's to be met.

Review Health Assessment

5.7 Statutory guidance requires that a review of a child's health plan must take place at least once every six months before a child's 5th birthday and at least once every twelve months after the child's 5th birthday. The review is to be undertaken by a registered medical practitioner, a registered nurse, or a registered midwife.

5.8 Review health assessments (RHAs) for looked after children residing in Trafford that are under the age of 5 years are carried out by Trafford Local Care Organisation (TLCO) health visitors, figure 2 shows that the compliance of RHA's completed in statutory timescale for the under 5's is now 90%.

5.9 The Looked After Children Health Team undertake yearly RHA's for all school-age children and 16- and 17-year-olds residing in borough. Until Quarter 4 the Looked After Children Health Team continued to experience significant staffing pressures due to staff sickness and maternity leave. Whilst the KPI for RHA's remains below the national threshold, figure 2 demonstrates that progress has been made towards meeting the KPI once staffing pressures improved. The Looked After Children Health Team have reviewed how the service was operating and how improvements could be made to refocus on the health needs of our children and young people.

This involves a child centred approach for example *A Looked After Child who was nervous to engage with the Looked After Specialist Nurse for their RHA and requested the nurse to wear a head band or bunny ears. This young person's voice was listened to and enabled the young person to engage positively in their health assessment.*

Dental Attendance

5.10 Data on dental attendance continues to be provided through joint working with Trafford Council. There are limitations to the reliability of this data due to it not usually being updated between health assessments, which for most children and young people is undertaken annually. Therefore, if a child or young person attends the dentist in the interim period before the next assessment, this information is not added to the child/young person's record in a timely way, therefore impacting on the accuracy of data reporting. Discussions have continued between the Named Nurse Safeguarding Children, Children in Care and Head of Service for Cared for and Care Experience Children to promote a joint approach to collecting dental data. The Looked After Children Health Team are also input dental dates when known following an RHA onto the Liquid Logic system so that the live data set that both health and social care use improves in accuracy. This has led to an increase in reporting from Q3 to Q4 as demonstrated in Figure 2.

5.11 The Greater Manchester Dental Recovery Pathway is now utilised by the Specialist Nursing Team.

5.12 The Looked After Children Health Team continues to promote accessing dental care at health assessments by signposting carers to NHS Choices and liaising with dental practices, raising awareness of the vulnerability of this group and sharing the evidence base behind the requirement for timely dental care.

Section 6: Partnership Working

6.1 A partnership approach is key to ensuring best outcomes for looked after children. The Looked After Children Health Team works closely with Trafford Council colleagues to ensure they have the correct information in a timely manner to provide a robust health offer. This includes following escalation processes to address issues as they arise.

6.2 The Looked After Children Health Team have participated as subject matter experts on the health of our children and young people in the following multiagency working groups:

- Missing From Home Demand Reduction meeting
- Permanence Panel meeting

6.3 A significant number of looked after children are affected by criminal and sexual exploitation. There is now a commissioned health worker based within the Trafford Complex Safeguarding Team (Shine) to lead on the health response to exploited young people. The Senior Specialist Nurse for Looked After Children works closely with the Senior Specialist Complex Safeguarding Practitioner (Shine) to ensure there is timely information sharing and support for the children involved.

Healthy Care Partnership

6.4 The Looked After Children Health Team continues to contribute to Trafford's Healthy Care Partnership, which is a health workstream of the Corporate Parenting Board to support a coherent and collaborative approach to meeting the health needs of looked after children across the health economy and with partner agencies.

6.5 The Named Nurse for Safeguarding Children and Looked After Children, or Senior Specialist Nurse for Looked After Children attend and engage in the Corporate Parenting Board.

6.6 The Senior Specialist Nurse along with the Designated Nurse Safeguarding Children and Looked After Children and the Complex Safeguarding Specialist Nurse delivered a presentation to the Trafford Corporate Parenting Board in May 2022 highlighting the need for connectivity across the borough to support the health needs of looked after children. Care Experienced Young people who were present at the meeting raised queries around support to access the gym, information on vaping and oral health which was later provided.

Section 7: Objectives and Priorities 2022/2023

7.1 **Looked after Children Health Team Objectives**

- Continued prioritisation of the completion of statutory health assessments in a timely way using the risk-based prioritisation tool.
- Continue to raise awareness of the health needs of our looked after children and develop pathways for coordinated care.
- Deliver a local comprehensive looked after children training package to run alongside the Trust-wide training offer to support staff to complete high quality health assessments in line with local processes.
- Complete Audits to seek assurance that health actions for unaccompanied asylum seekers are being actioned after IHA; dental health is being captured and actions are being followed up following both IHA's and RHA's
- Ensure that completion of Care Leaver Health Summaries are up to date and timely.
- To develop a working relationship with the new Named Doctor for Looked After Children to enable service development.
- Continue to work with the Local Authority to enable greater accurate data reporting on the health needs of young people using the live data.
- Continue to work with the Local Authority and Named Doctor to ensure there is a clear process for enabling timely health assessments with appropriate signed consent.

Section 8: Conclusion

8.1 Looked after children in Trafford continue to receive a service from a dedicated and passionate team of health professionals working to ensure their health needs are met to a high standard. This includes delivering a creative, 'needs-led' service to all regardless of the placing LA.

8.2 2022/2023 has seen a continued commitment to the looked after children health agenda across the Trafford health system at both operational and strategic levels.

8.3 The MFT Trafford Looked After Children Health Team will continue to work with relevant providers and commissioners in borough and across Greater Manchester to strengthen existing systems and pathways and strive to develop a service which makes a positive difference to looked after children in Trafford.

SECTION J

Mental Health Safeguarding Team Annual Report 2022-23

(including overview of Child & Adolescent Mental Health Service (CAMHS)

1.1 MFT is committed to providing outstanding, patient centred care, that meets the needs of physical health alongside mental health. It is crucial that patients feel safe, listened to and have confidence in the knowledge and skills of our staff. At the end of 2022-23 a the mental health strategy was developed, this will be consulted upon and launched in 2023-24. The strategy builds on the work that has been completed this year to scope and review systems, policies, and procedures in place to support staff to provide the best possible care and treatment according to legislation, national guidance, regulatory, and audit standards particularly focussing on CQC regulatory standards of monitoring the Mental Health Act. The strategy sets the direction for the delivery of quality services within MFT for the next three years. The strategy will support patients who have a mental health difficulty throughout their journey of care though MFT emergency departments, inpatients, outpatients and community. There are five key aims of the strategy and this years Mental Health Report completed by the Mental Health Safeguarding team reports on the progress of the safeguarding team against the strategic aims.

Figure 1: MFT Mental Health Strategy (currently under consultation) Aims

Aim 1: Quality of Care Delivery:

To improve the quality of care delivered to our patients when they access services at MFT

Aim 2:

Patient Experience:

To ensure that our patients, of any age, have a positive patient experience through pathways for mental health

Aim 3: Education, Training, and Supervision

To ensure our workforce has the right knowledge, skills and attitude to recognise and care for patients, carers and families with mental health needs

Aim 4:

Policies, protocols, and service level agreements:

To ensure that our staff are supported to deliver evidence-based practice

Aim 5: Outcomes:

To ensure that we will deliver outcomes that matter to our patients, as well as to organisations

2. Quality of Care Delivery

2.1 Suicide Prevention

The Mental Health Safeguarding Team (MHST) have continued to support the clinical areas within the Trust with the implementation of the Suicide Prevention Policy by:

- Visits to ward areas and outpatients to support with the Environmental Ligature Risk Assessment (ELRAT) implementation.
- Delivery of “Train the Trainer” in Ligature Risk Management training.
- Induction for new starters, at North Manchester General Hospital (NMGH), in ligature risk management
- Regular telephone support to ward and outpatient areas regarding management of ligature risk.

- Working collaboratively with the Mental Health Liaison Team (MHLT) to reduce ligature risk environmentally and to safeguard patients at risk of self-harm or suicide.

2.1.1 Following learning from Safeguarding Adult Reviews and serious incidents the use of the of the ELRAT and ligature risk assessment and incident management training has been closely monitored and all site Safeguarding Committees have been tasked to ensure all in patient wards have an ELRAT completed and 80% of nursing staff have completed the ligature incident and risk assessment training.

2.1.2 A review of the use of the Integrated Care Pathway for Self Harm and Suicide in Emergency Departments identified significant assurance that a referral is made to the Mental Health Liaison (MHLT) when a patient discloses thoughts thoughs of suicide or self harm in the Emergency Departments (ED) in Wythenshawe or Trafford Urgent Care with partial assurance at MRI. The SMHT have priortised working closely with MRI ED to promote completion of referrals to MHLT when a patient is at risk of suicide and self harm.

2.1.3 The team are also involved in regular discussions around risk and are currently working with the Trust Estates and Facilities team and stakeholders regarding the risk that balconies around the Trust could pose and the strategies required to mitigate and manage this risk.

2.2 **Least Restrictive Interventions and Restraint**

2.2.1 An annual report on Restrictive Interventions practice has been completed. A review of the Ulysses incident reporting system (1/4/2022 – 31/3/223) indicates that there were **686** restraint incidents reported compared to **906** in 2021/22.

2.2.2 In comparison with 2021/2 report there has been a decrease in reporting of restrictive interventions in RMCH to **472** (**689** 2021/22 and **271** 2020/21). The **472** incidents involved **39** children with multiple incidents being reported for a small cohort of children and young people Analysis of the multiple incidents reported, identified that the children or young people who has the most frequent incidents were detained under the Mental Health Act and the incidents reported were part of the child or young person's care and treatment, most frequently safe holding for administration of naso gastric feeding and fluids. RMCH staff have received training in restraint with CAMHS staff at Galaxy house receiving a bespoke training package meeting Restraint Reduction Network (RRN) standards.

2.2.3 The MFT Enhanced Supervision Security Policy identifies the role of the enhanced security officer and the documentation and recording of restraint. The security service record and report on all restraint incidents through a security dashboard.

2.2.4 Analysis of data from the security team has identified the effectiveness of the ESSO policy in applying least restrictive practice. In February and March 2023, Security services, have been measuring the impact of taking a less restrictive intervention approach strengthening communicating with patients rather than restraining. The reporting identifies that the majority of occasions where ESSO is used, least restrictive interventions are applied.

2.2.5 The MFT Group Head of Security has reviewed restraint training according to RRN standards and a task and finish group will be established in 2023-24 to review the ongoing training provision in relation to restrictive intervention practices for clinical staff. The group will evaluating a Trust wide approach for clinical staff who support challenging patients as part of existing clinical policies such as Enhanced Observation of Care Policy, to receive upskilled training to ensure compliance with Restrictive Intervention practices. The aim is to provide a more person centred care programme for patients and reducing the requirement for Security unless behaviour escalates. The Trust is required to demonstrate to the CQC its use of less restrictive interventions and how robust care plans can support a patients needs without necessarily resorting to restraint.

3. Patient Experience

3.1 Advocacy is essential in enabling patients with mental health difficulties to speak up, raise concerns and share their experience. This year the baseline assessment for Advocacy services for adults with health and social care needs NICE Guidance NG227 has been completed. A point prevalence exercise of the use of advocacy at ORC site identified that frontline staff understood the importance of providing an advocate to support patients who cannot advocate for themselves but were less clear on how to access these services. Therefore a seven minute briefing was developed and shared Trust wide to support staff on recognition of patients requiring advocacy and how to refer to advocacy services.

3.2 MFT has two Mental Health Act (MHA) and Mental Capacity Act (MCA) officers who support the Trust in application of legislative standards especially in application of patient's rights of the Act. This year there Trust has supported **24** MHA appeals.

3.3 The team have been involved in supporting staff complex cases involving mental health and physical health throughout the year. As a result of the teams' involvement, patients received the appropriate care and treatment. Figure 2 is a case example.

Figure 2: Case Example

An inpatient within The trust had absconded from the ward. Concerns were raised regarding his physical health due to him having an ulcer on his foot. Patient was non-compliant with treatment and reluctant to trust healthcare professionals due to his mental health condition which manifested itself as delusional and paranoid beliefs.

MHST contacted the Community Mental Health Team (CMHT) and raised concerns regarding this and explained the possible implications if the patient's foot was left untreated. MHST team worked jointly with the CMHT, MHLT and the ward. Subsequently the patient was admitted and detained under section 3 of the MHA. As a result, the patient has received the treatment he needed and has made a full recovery regarding his physical health.

4. Education, Training and Supervision

4.1 This year level 2 mandatory Mental Health Awareness training and Level 3 continous professional development training have been developed as a elearning package and are available through the Learning Hub. The team has continued to deliver Ligature Management Train the Trainer sessions which are well supported by the ward areas with good attendance.

4.2 MHST receive calls on a daily basis regarding suicidal patients in inpatient, outpatient and community settings. Calls include giving advice on:

- Dealing with suicidal patients and patients at risk of self-harm.
- Altered and challenging behaviours.
- Abuse to staff from patients.
- Missing patients.
- Independent Mental Health Advocates.
- Mental Health Act (MHA).
- Mental Health Law.
- Mental Health Tribunal.
- Deprivation of Liberty Safeguards (DoLS).
- Best Interest Assessments.
- General enquiries to support patients with various mental health conditions.

4.3 Support is offered to staff who have experienced abusive behaviour from patients or members of the public.

4.4 The team have recorded **3,855** contacts of providing advice and support to staff this year.

4.5 The MHST have provided bespoke training to specific groups of staff including:

- Internationally recruited Nurses Training.
- Altered behaviour training – aimed at band 2 health care staff.
- Training Nursing Associates – Mental Health Awareness Training.

5. The MHST team has also been offering bespoke training to ward areas and community teams see **figure 3.**

Figure 3: Training delivered by the MHST

	Q1	Q2	Q3	Q4	2022-23 Total
Altered behaviours and use of the Broset tool			55	103	**158**
Mental Capacity Act Training	52	54	100		**206**
Mental Health Act Training	112	14	39	44	**209**
Ligature Environmental Risk Assessment and Incident Management Training (train the Trainer)	60	13	17	49	**139**
Reasonable adjustments care plan training			61		**61**

6. Policies, Protocols and Service Level Agreement

6.1 MFT has a suite of policies, guidelines and associated training to support frontline staff in the care of distressed patients, the application of Mental Capacity Act, Mental Health Act and Deprivation of Liberty Safeguards to support staff in the legal application of care and treatment to detained patients and people with mental health difficulties. The safeguarding, mental health and learning disability nurses provide advice, consultation and training in supporting staff in least restrictive care and treatment planning for people with learning disabilities, autism or mental health concerns.

6.2 MFT launch of Hive Electronic Patient Record Systems has supported patients with a mental health condition by allowing early recognition of support needs and remote quality and auditing by the Safeguarding Mental health Team.

6.3 The Mental Health Act Policy has been significantly streamlined to avoid repetition and to make the policy user friendly and the content specific for the roles and responsibilities of MFT colleagues in applying the Mental Health Act.

6.4 The Prevention and Management of Restrictive Interventions for Adult Patients Policy has been updated in 2022 in line with national guidance[90], learning from serious incidents and the implementation of Hive. Documentation of least restrictive interventions is recorded on Hive through a flow sheet and there is a capacity to complete reporting through Hive on restraint incidents.

6.5 The Rapid Tranquilisation: Guidance for use of medication to manage disturbed behaviour in Paediatric patients due to potential for aggression, severe agitation and violent outbursts [91] and a Rapid Tranquillisation: Pharmacological management guidance for acute behavioural disturbance in adult patients to minimise the potential for aggression, severe agitation and violent outbursts[92] are being reviewed through an ongoing task and finish group to look at the connectivity of the Prevention and management of restrictive interventions and the rapid tranquilisation policies to ensure the policies can be applied together consistently and Hive documentation supports this.

6.6 The Prevention and Management of Missing Inpatients, including adults, children and young people has been reviewed in light of two high impact learning incidents. The review afforded the opportunity to ensure the policy was more streamlined in its approach, legislation and instructions for staff with a focus on assessment of risk and action planning to mitigate the risk which is vitally important to reduce the risk of patients going missing from care was updated.

6.7 In 2022 the Management of Children and Young People in Crisis who Require an Inpatient Admission as a Place of Safety [93]was launched and provides staff with a lawful framework of when and how to use restraint.

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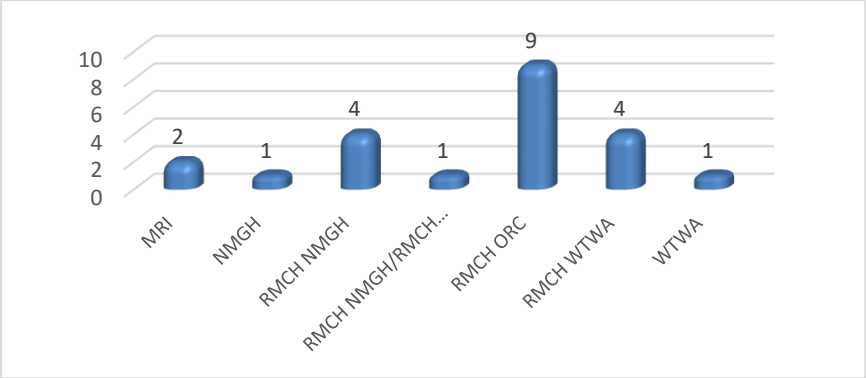
[90] Care Quality Commission (2022) Out of sight - who cares? Restraint, segregation and seclusion review
[91] Rapid Tranquilisation: Guidance for use of medication to manage disturbed behaviour in PAEDIATRIC patients due to potential for aggression, severe agitation and violent outbursts
[92] Pharmacological management guidance for acute behavioural disturbance in ADULT patients to minimise the potential for aggression, severe agitation and violent outbursts
[93] Management of Children and Young People in Crisis who Require an Inpatient Admission as a Place of Safety

The safeguarding children team have implemented this policy in 2022-23 working closely with RMCH collegues and the Manchester "Take a Break" multi agency partnership group implementing the policy in line with Greater Manchester Children in Crisis framework[94]. Figure shows the children admitted to MFT from implementation of the GM guidance in August 2021 until January 2023.

Figure 3: Young People/Child in Crisis Hospital Admissions per MFT site.



The children and young people often have a prolonged stay in hospital care and this is identified in **Figure 3**, with **Figure 4** indicating the Local Authority responsible for the young people.

Figure 4: Young People/Child in Crisis Hospital Admissions per MFT site.

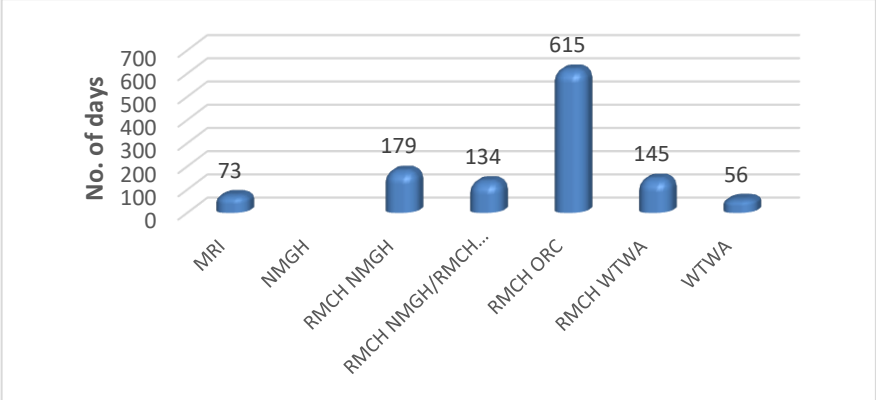
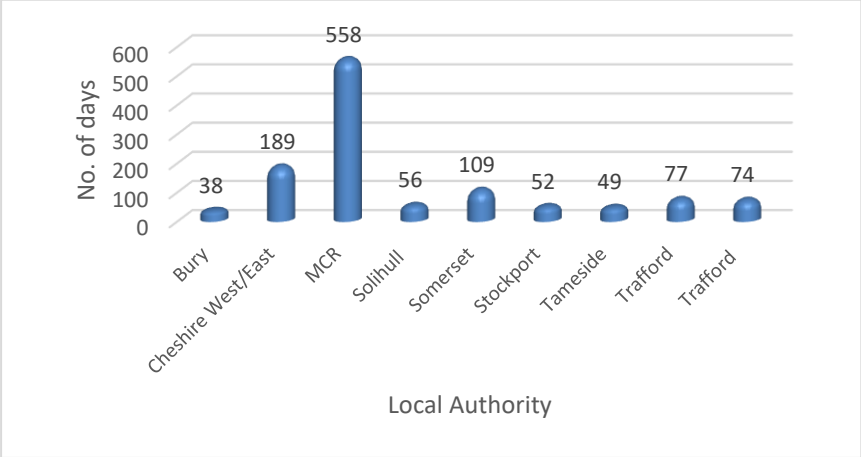


Figure 5: Length of Stay per Local Authority



[94] Greater Manchester Health and Social Care Partnership (2022) Children and Young People in Crisis Escalation & Support Framework

7. Outcomes

This year a scoping exercise[95] completed to review systems, policies, and procedures in place to support staff to provide the best possible care and treatment according to legislation, national guidance, regulatory, and audit standards particularly focussing on CQC regulatory standards of monitoring the Mental Health Act. The scoping identified evidence of systems and processes in place across MFT that demonstrate implementation of national standards and recommendations. The scoping identified that an Assurance Framework was required to demonstrate expected standards are routinely applied in practice, for the benefit of patient. Subsquently an assurance workshop was held to identify the monitoring of mental health activity across safeguarding committees and to inform the development of the mental health strategy and action plan which will be monitored by the Mental Health subgroup and reported to Group Safeguarding Committee in 2023-24.

In January 2023 the Care Quality Commission asked MFT 20 questions in the Assessment and Monitoring of Mental Health (Emergency Departments) The questions reviewed the following areasleadership

- Leadership and monitoring of the mental health activity, this is completed through the Mental Health sub Group reporting to Group Safeguarding Committee and Manchester and Trafford Strategic Urgent Care Board.
- Support to the workforce provided through mandatory level 1 and 2 training, continuous professional development training at level 3, mandatory ligature risk assessment training and bespoke training from the MHLT and SMHT
- Multi Agency operational working including multi agency review of missing patients from ED.
- Collaborative working with MHLT provided by GMMH delivered through service level agreement[96] and standard operation guidance[97]
- Monitoring of the use of MHA sections, including section 136 in ED and section 5 (2).completed in line with MHA policy.
- Provision of a safe environment for assessment in ED in accordance with Royal College of Emergency Medicine standards[98]

8. Forward Plan

8.1 Over the next 3 years MHST will be heavily involved in the roll out and implementation of the Mental Health Strategy.

8.2 The team is currently preparing for Mental Health Awareness Week and will be travelling around the Trust in support of the theme which is Anxiety Awareness.

8.3 A Mental Health Action plan has been developed with the following priorities for 2022/23. These priorities will be monitored and actioned by the Mental Health Subgroup.

[95] Nursing, Midwifery abd Allied Health Professional Board Paper November 2022, To provide an overview to Professional Board members following a scoping exercise of mental health care across the Trust.
[96] Manchester Mental Health Liaison Service Level Agreement 2019
[97] Mental Health Liaison Service Operational Procedure – Manchester and Trafford Services 2021
[98] Royal College of Emergency Medicine Mental Health in Emergency Departments 2021

Figure 6: Mental Health Action Plan Priorities

Objective	Description
1	MFT provides integrated, holistic care, addressing the mental and physical health needs of all their patients, with parity of esteem between physical and mental health care provision.
2	The views of patients are incorporated into plans for quality and service improvement
3	Compliance with the Use of Force Act 2018 and Statutory Guidance through Least Restrictive Interventions and Restraint
4	Managing risks associated with mental health presentations
5	Safe Environments There is a safe therapeutic environment in both emergency departments and inpatient wards.
6	Mental Capacity Act Application
7	Implementation of Dementia Care Strategy
8	Initiatives to enhance the mental health and wellbeing of staff across the organisation
9	All patients in mental health crisis receive timely and quality treatment when in urgent and emergency Departments (ED) in crisis.
10	NICE Guidance (CG192) Antenatal and postnatal mental health: clinical management and service guidance implemented across Saint Mary's Managed Clinical Services (MCS)
11	Supporting children and young people (CYP) with mental health needs in acute paediatric settings

8.4 **Key priority areas of this plan will be**

- The Prevention and Management of Restrictive Interventions for adult patients requires further review to incorporate application to children and young people.

- The least restrictive interventions and restraint task and finish group chaired by Trust Group Head of Security and Lead Nurse Safeguarding will report to the Mental Health sub group in June 2023 and Group Safeguarding Committee in August with the proposals of Restrictive Interventions Training. The aim of is to provide members with recommendations for consideration on the implementation of Restrictive Intervention training for clinical staff who are assessed under a training needs analysis as requiring additional skills to support challenging and complex patients.

9. Child and Adolescent Mental Health Service – Overview

9.1 9.1. MFT CAMHS are specialist NHS mental health services for children and young people covering Manchester Salford and Trafford. We offer assessment, diagnosis, treatment and support for young people who are experiencing problems with their emotions, behaviour or mental health across a range of conditions and specialisms.

9.2 MFT CAMHS have grown as a Clinical Service Unit/directorate expanding its locality footprint and its provision from 22 to 44 services. The CSU was rated 'Outstanding' by CQC in 2016 and 2019. A visit to Galaxy House in 2021 resulted in actions relating to play area, access to care planning and assessments, and have now all been addressed.

9.3 CAMHS CSU is expected to continue to grow throughout 2023/24 and within progress delivering a large-scale transformation programme that seeks its modernisation (applying digital technologies) and implementing new care model (THRIVE) and patient flow (demand and capacity) modelling (CAPPA informed). This business plan outlines the future projects taking place within the CSU and plans for expansion.

9.4 Under the Long-Term Plan (2019), the NHS is making a new commitment that funding for children and young people's mental health services will grow faster than both overall NHS funding and total mental health spending. This means that children and young people's mental health services will, for the first time, grow as a proportion of all mental health services, which will themselves also be growing faster than the NHS overall.

9.5 **The NHS Long term Plan (LTP) requires by 2023/24:**

- 345,000 additional CYP aged 0-25 will have access to support via NHS-funded mental health services and school- or college-based Mental Health Support Teams (in addition to the FYFVMH commitment to have 70,000 additional CYP accessing NHS services by 2020/21).
- There will be a comprehensive offer for 0-25 year olds that reaches across mental health services for CYP and adults.
- The 95% CYP Eating Disorder referral to treatment time standards achieved in 2020/21 will be maintained.
- There will be 100% coverage of 24/7 mental health crisis care provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions
- CYP mental health plans will align with those for children and young people with learning disability, autism, special educational needs and disability (SEND), children and young people's services, and health and justice

9.6. In additional to the ask set out within the NHS LTP recovery from Covid-19 pandemic is expected to see a continued increase in demand – and within this acuity - for mental health support, care and treatment.

9.7. In 2022/23 the CSU moved to a Business as Usual (BAU) within completing moving to a comprehensive Electronic Patient Record (EPR) system with a shared instance of Greater Manchester Mental Health Trust (GMMH) PARIS EPR, which sees the breath services and localities within CAMHS CSU on boarding by April 2022. Fulfilling the NHS Long Term Plan (2019) requirement that all providers, across acute, community and mental health settings, accelerate the roll out of Electronic Patient Record (EPR) systems.

9.8. The mental health programme has ring-fenced and committed funding (Mental Health Investment Standard), which is required to grow the workforce significantly and expand and transform mental health services. This recurrent funding has already been confirmed and communicated in the Mental Health Implementation Plan 2019/20 - 2023/24, and it is expected that funding should be used to deliver the Mental Health Long Term Plan (LTP) commitments.

9.9. **Development of Home Intensive Treatment (HIT) Teams and delivery of Rapid Response Teams (RRT)**

The NHS Long Term Plan sets out that by 2023/24 all children and young people experiencing a mental health crisis will be able to access age appropriate crisis care 24 hours a day, via NHS 111, seven days a week combining crisis assessment, brief response and intensive home treatment functions.

MFT CAMHS CSU in 2021 is required, as part of the mandate outlined above, to develop and operationalise HIT new services. The new service will be community-based service set up to support young people experiencing severe enduring and acute mental health issues. The main aim of HIT is to provide an alternative to admission - avoiding hospital admission - through intensive home and treatment and support and enable discharge from inpatient services back into the community.

The new service will need to be able to provide intensive home treatment packages of care; including the option to provide multiple visits per day (dependent upon capacity and acuity of current caseload).

In addition to developing the new service outlined above MFT CAMHS needs to consider the termination of the sub contacting arrangement with PCFT and direct deliver RRT (rapid brief response and intervention) inhouse. Within this ensuring integrated clinical pathways and improve clinical coordination.

9.10. **Inpatient Lead provider Collaboratives (LPC)**

As provider of CAMHS inpatient beds it will be essential that MFT supports and actively engages within the GM CAMHS LPC led by Pennine Care NHS Foundation Trust – and through this the national LPC agenda

This agenda is outlined within NHS Long Term Plan requiring specialised inpatient services to move towards integrated commissioning with local services and the devolution of some services. The LTP states “in mental health this intent is being delivered through devolving responsibility for specialised mental health services to Provider Collaboratives, previously piloted as New Care Models”.

The GM CAMHS LPC financial case continues to be developed and requires a robust due diligence process, following queries associated with the proposed baseline allocation, in which future growth assumptions and management of system risk will be delivered.

It is essential that the LPC addresses all associated risks to ensure a financially sustainable model is established.

9.11. **Performance**

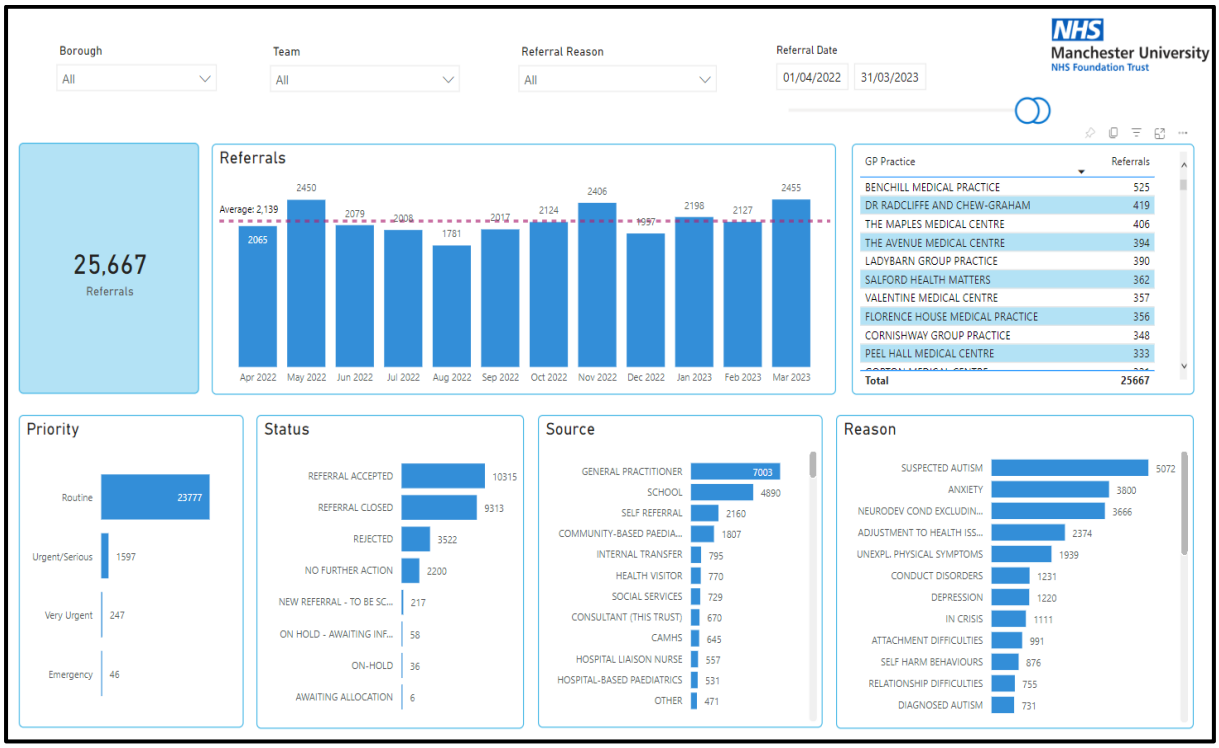
The following sections provide information, from Hive PowerBi dashboards, relating to CAMHS:

- Referrals

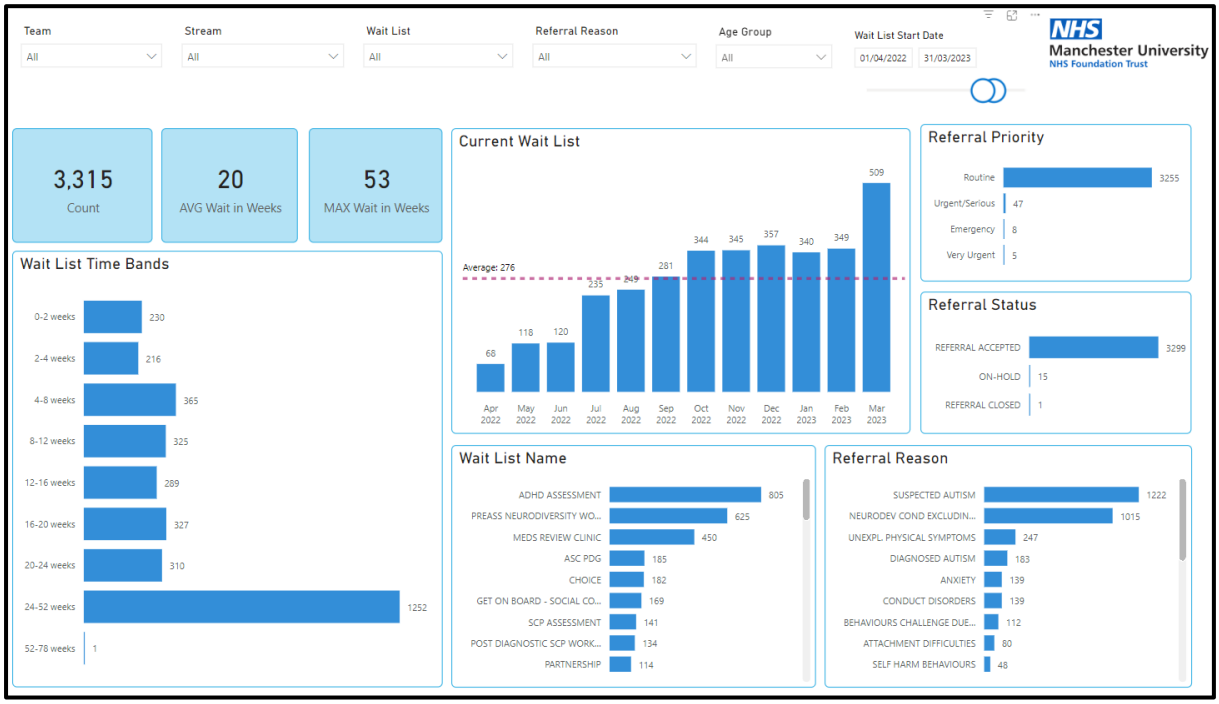
- Waiting Times
- Activity and Demand

The dashboards provide a brief overview of metrics which are reported through RMCH Governance structures.

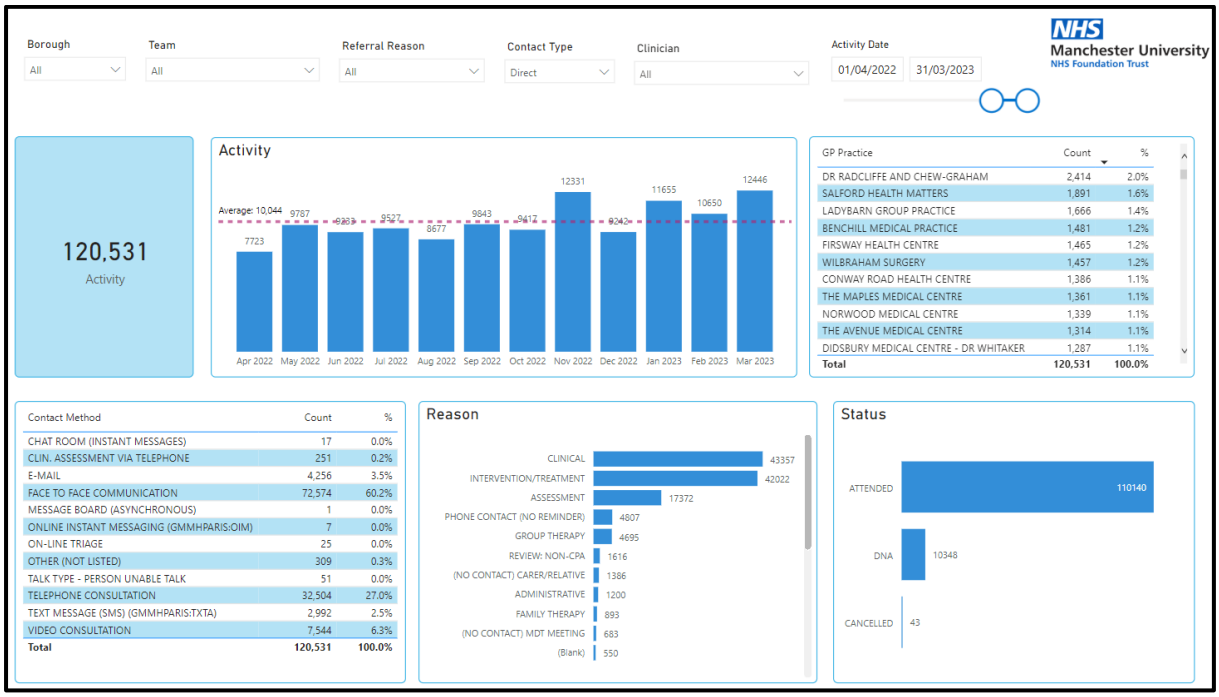
- **CAMHS Referrals**



- **CAMHS Waiting Times**



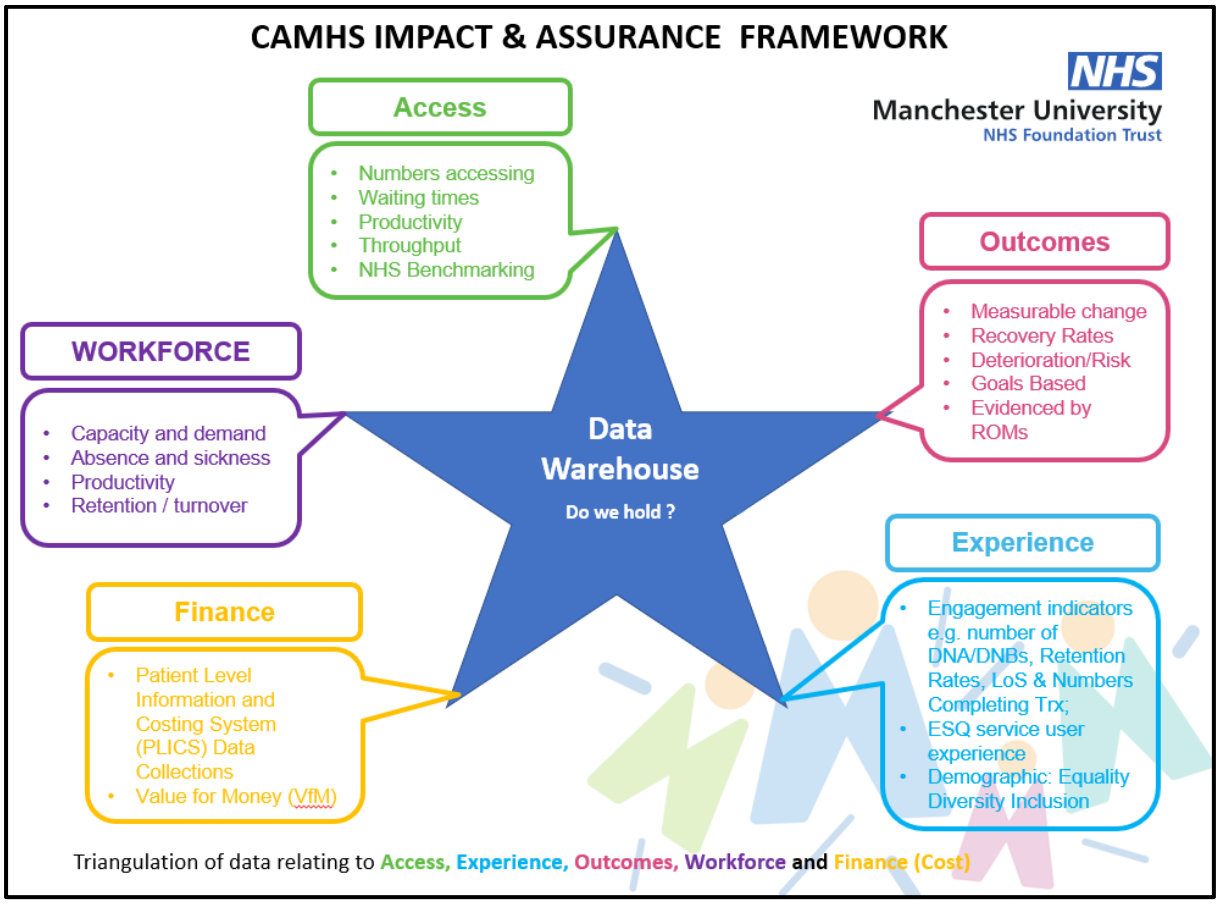
- **CAMHS Activity**



- **CAMHS Activity and Demand**

- **Improving Outcomes and Experiences of Care**

The CAMHS Directorate in auditing and evidencing the impact this strategy, has moved to a more rounded quality agenda and looking beyond just considering activity in isolation as a means in which to assure services both internally and externally with commissioners. As such the triangulated methodology, shown below, captures a more purposeful means to increase validity in evidencing the quality of our delivery and enable the voice of those using our service to be importantly included.



SECTION K

Learning Disability and Autism Team Annual Report 2022-23

Section 1: Introduction

1.1 MFT aims to deliver high quality, safe, person-centred care which provides people with learning disabilities and/or autism and their families and carers the most positive experience of MFT's services.

1.2 The Learning Disability and Autism Safeguarding Team are part of the Safeguarding Team. The team covers the whole of MFT hospital/inpatients sites as an an advisory service to support the care and treatment of patients who have a diagnosed Learning Disability (LD) and/or Autism.

1.3 The aim of the team is to empower the MFT workforce to be confident in working with patients with Learning Disabilities and Autism to deliver efficient and effective personalised care to these individuals.

1.4 In order to improve the care and experience of people with learning disabilities and/or autism who access MFT services, MFT has produced a 3 year strategy "Our plan for people with learning disabilities and/or autism, their families and carers. 2022–2025".

The priorities of this strategy are;

- Respecting and protecting people's rights
- Inclusion and engagement
- Workforce
- Learning disability services standard.

The safeguarding team have produced an update of how they supported the Trust to complete the aims of this strategy.

Figure 1: Update of how the safeguarding team will support the Trust to complete the aims of the LD Strategy.

Respecting and Protecting Rights: We will ensure we meet our Equality Act Duties to patients with LD and/or autism and that the wider human rights of our patients are respected and protected, as required by the Human Rights Act
Reasonable Adjustment Care Planning: The Learning Disability and Autism Safeguarding Team have supported the development and led the implementation of the reasonable adjustment assessment tool and care planning in all inpatient areas, utilising the Hive system This has resulted in patients with a learning disability and or autism have a specific individualised care plans to meet the patients need during their inpatient stay, This year the team completed **891** quality care checklists for every patient flagged to have a learning disability admitted to MFT hospitals in 2022/23. The aim of the quality care checklist is to review the patients reasonable adjustment assessment and care plan to ensure all patients are offered the best quality care and frontline staff receive support and advice to deliver the care. In addition, the team have supported clinical areas in development and implementation of a hospital/MCS senior nurse review documented on Hive of all patients flagged on Hive that have a learning disability. The team ensure that hospital passports for people with a learning disability and or autism updated in the community are shared with the acute services and included in the patient's health records on Hive. All MFT staff have access to the 'easy health' resources on the MFT intranet This will help support staff in communicating with patients in their journey in MFT services. The Learning Disability and Autism Safeguarding Team are represented on each hospital learning disability and autism delivery group which promotes sharing of information and supports learning to improve patient care.

The learning disability team regularly deliver training through planned training sessions and during daily wards visits, are teaching and showing acute staff the requirements and expectations of assessments and care plans in the Hive system, supporting application of mental capacity assessment process (MCA) awareness of appropriate application of the ReSPECT process.

Inclusion and Engagement: We will ensure that all patients/service users with LD and/or autism and their families and carers are empowered to be partners in the care they receive.

The Learning Disability and Autism Safeguarding team attend the MFT Patient and carer forum network meetings held by the Community Learning Disability Matron. Further work is required to increase the numbers of patient/carers attending this meeting to develop ongoing functionality.

The key messages arising from the Patient and Carer Forum are:

- The forum would like to contribute to discussions around care for patients with learning Disabilities and Autism in MFT hospitals and are happy to comment on documents being created to support these patients such as, the development of the Hospital Passport and Reasonable Adjustment Care Plans.
- The forum enjoys hearing success stories of patients with Learning Disabilities and/or Autism accessing our hospitals
- The forum would like to gain more knowledge around the role of the Learning Disability Safeguarding Nurses and their role in supporting staff and empowering staff in caring for patients with Learning Disabilities and Autism
- The forum would like feedback from task implementations which they have were involved in, such as their contribution to the development of frameworks and policies which benefit Learning Disability and Autism care.

All clinical areas have a learning disability and autism board, - this shows the learning disability and autism teams contact details.

The Learning Disability and Autism Champion programmes is now integrated into areas of MFT services. (MRI, Eye and Dental, SMH, CSS, Research and Innovation, WTWA). Each month the Champion programme covers a new topic which is current and relatable to all practice areas.

AJ's Sing and Sign choir is a group of individuals who attend AJ's day services who have a diagnosed Learning Disability and/or Autism, the choir utilises Makaton to promote the alternative use of communication aids to support individuals with Learning Disabilities and/ or Autism.

The choir visit the Hospitals to share their talent by signing and singing to a range of songs, they visit on Learning Disability Awareness Week and often attend the MRI and perform for staff and patients throughout the year.

Workforce: We will have the skills and capacity to meet the needs of people with LD and/or autism by providing safe and sustainable staffing, with effective leadership at all levels.

MFT offer mandatory e learning training with the following objectives:

- Increase awareness of supporting people with learning disabilities and autism
- Consolidate understanding what reasonable adjustments can be employed to improve the hospital experience for patients with a learning disability and autism
- Provide an explanation of help available to staff to support patients and their carer's, or amily carers.

The compliance for LD and Autism eLearning awareness training as of March 2023 is **82.29%** for the Trust overall. Since April 2022 there have been a steady monthly increase in staff completing the training as outlined in the table below.

Learning Disability and Autism Awareness Training											
Apr 2022	May 2022	June 2022	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023
74.22%	74.44%	75.41%	78.17%	78.57%	78.76 %	79.46%	80.42%	81.03%	81.75%	82.00%	82.29%

A working group has been established to review the requirements of and lead on implementation of the Oliver McGowan Training. The working group are reporting into the Trust wide Learning Disability Steering group which reports to Group Safeguarding Committee.

The current e learning is being reviewed and updated to ensure that the e learning package is in line with the mandated Oliver McGowan e learning. In addition, feasible and achievable options are being explored to deliver the face to face and tier 2 component of the training, working closely with system wide NHS GM Integrated Care Board colleagues.

In 2022, **124** frontline staff completed a 2-day level 2 working with people with learning disability course facilitated by the University of Salford and co delivered by people with lived experience.

A questionnaire was sent out to the course attendees and the following feedback was received:

- 83% of the attendees scored the course a 5 out of 5 as being beneficial and educational.
- The attendees explained that the course raised awareness regarding complexities associated with living with a Learning Disability and how the impact of making Reasonable Adjustments can benefit patients care, provide alternative ways to communicate with patients with Learning Disabilities and/or Autism to support their hospital admission and the use of a Hospital Passport. Most of the course attendees explained that strategies to aid communication with patients with Learning Disabilities and/ or Autism was the main learning they took from the course.
- 91% of the attendees found the course beneficial to their role.
- Many of the attendees have had the opportunity to implement changes within their working environment based on learning from this course, they explained that they are developing communication documents in relation to their ward area and department to support patients with Learning Disabilities and/ or Autism. They also reported that the course raised awareness regarding the use of medical jargon when communicating with patients with Learning Disabilities and/or Autism. Majority of the attendees mentioned the importance of making Reasonable Adjustments for patients with LD/ASD.

In addition, the Learning Disability & Autism safeguarding team offers training to new starters, internationally recruited nurses and trainee nurse associates. The team also offer bespoke training for ward areas and departments when requested. The team have delivered **196** sessions to staff over the last year on awareness of Learning Disabilities and/ or Autism and caring for that cohort of patients in our MFT hospitals.

The team review all MFT incidents received for patients with a learning disability and review them jointly with our colleagues in the community to highlight elements and themes that have emerged to direct future work. This year the team reviewed **4720 i**ncidents involving patients with Learning Disabilities and/or Autism. The main themes identified below:

Theme	Additional Information
Medication Management	Issues with Medication Administration, lack of supplies to administer medication and delays in medication for discharge
Communication/Handover of Care	Concerns raised around lack of handover involving patients with Learning Disabilities and Autism, between ward moves and with community services
Pressure Areas	Pressure sores noticed during hospital admission
Behaviours that challenge and the use of physical intervention	Incidents of Disruptive and Abusive Behaviour, Self- Harm and Ligatures,
Falls	Incidents involving patients who have fell at the Hospital
Safeguarding Concerns	Emotional, Neglect and Domestic Violence Related.

This year there have been **2005** contacts to the learning and disability safeguarding team where support and advice has been provided.

Learning Disability Service Standards: We will work in partnership with specialist LD services to fulfil the objectives of national policy and strategy.

In partnership with the MFT Learning Disability Steering Group a Care of Inpatients with a Learning Disability and/or Autism in an acute hospital setting policy has been developed.

The learning disability team have supported the MFT operational learning disability groups to benchmark MFT against the domain standards Experiences of being in Hospital for people with a learning disability and autistic people' CQC 3/11/22[99] The learning disability team have worked closely with medical and governance team to support the MFT contribution to LeDeR[100]. This year the team completed **64** Best Practice Reviews identifying the following main areas of learning are: - The need to explore further the rationale of DNACPR forms stating "Learning Disability" - The requirement to strengthen application of the Mental Capacity Act - To improve the application of Reasonable Adjustments - To increase DoLS applications for patients who are deemed not to have capacity to consent to treatment in hospital - To improve documentation of best interest meetings - To strengthen the use of an IMCA for patients with no appropriate Next of Kin - To include a Hospital Passport in patient records. - To increase referrals to the Learning Disability Safeguarding Team There is also guidance in development to identify the roles and responsibilities of MFT staff contribution to LeDeR	

Areas for development 2023-24 – these will inform the key priorities for the LD Workplan

- Every patient should have the correct flagging on the Hive system. Currently only patients with a Learning disability diagnosis are flagged, and the next step is to enable patients with a single diagnosis of Autism to be flagged (outside of the current problem list) to ensure they are receiving the right quality care for their needs.
- There needs to be increased communication and sharing of good practice between community and acute services through strengthening of joint working relationships.
- The development of policies and standard operation procedures (SOP) are nearing completion. The Learning Disability and Autism inpatient Policy and the LeDeR SOP will be finalised and implemented in 2023-24.
- Every patient will have a Reasonable Adjustment Care plan to evidence Reasonable Adjustments being made for patients with Learning Disabilities and/ or Autism

[99] Experiences of being in Hospital for people with a learning disability and autistic people' CQC 3/11/2
[100] LeDeR Learning Disabilities Mortality Review Programme LeDeR reviews deaths to see if lessons can be learned about how people are cared for.

Agenda Item 11.3

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Chief Nurse
Paper prepared by:	Kathy Murphy, Director of Nursing and Midwifery Jen Sager, Assistant Director of Quality and Safety
Date of paper:	July 2023
Subject:	Maternity Services Assurance Report
Purpose of Report:	Indicate which by ✓ • Information to note ✓ • Support ✓ • Accept ✓ • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Excels in quality, safety, patient experience, research, innovation, and teaching To improve patient safety, clinical quality, and outcomes To improve the experience of patients, carers, and their families
Recommendations:	The Board of Directors are asked to note the following: • Progress and ongoing monitoring of compliance following the CQC inspections of maternity services. • Assurance of ongoing compliance of Ockenden Immediate and Essential Actions (IEAs)[1] received at Quality and Performance Scrutiny Committee • Update on Maternity Self-Assessment Tool (MSAT) • Executive summary of maternity and neonatal safety dashboard
Contact:	Name: Alison Haughton, CEO, Saint Mary's MCS Tel: 0161 276 6124

1. Introduction

1.1. This report provides:

- An update on progress and ongoing monitoring of compliance following the Care Quality Commission (CQC) inspections of maternity services and receipt of a Section 29A Warning Notice (24th March 2023)
- Assurance of ongoing compliance of Ockenden Immediate and Essential Actions (IEAs)[2] received by the Quality and Performance Scrutiny Committee
- An update on the Maternity Self-Assessment Tool (MSAT)
- Maternity Incentive Scheme (MIS) Year 4 Q4 22/23 reports of Avoidable Term Admissions in Neonates (ATAIN) as required within Maternity Incentive Scheme reporting.
- An executive summary of the Maternity and Neonatal Safety Dashboard

2. Update following CQC inspection

2.1 The CQC announced an inspection of maternity services provided by Manchester Foundation Trust (MFT) on Friday 3rd March 2023 which subsequently took place on site between 7-9th March. Data relating to the 'safe' and 'well led' CQC domains was submitted to the CQC during the inspection period.

2.2 SM MCS were issued with a Warning Notice issued under Section 29A of the Health and Social Care Act on the 24th of March 2023 pertaining to the inspection of Maternity Services across all 3 sites.

2.3 On 19th April 2023 governance arrangements were established, overseen by an executive led group, reporting to the Board of Directors.

2.4 A Project Management Office (PMO), was set up to coordinate the response and work of the three workstreams, supporting the tracking and delivery of the 101 actions set out in the compliance action plan, within agreed timescales to meet the workstreams identified in Fig 1.

Workstream	Workstream overview
Triage	To further develop the triage service to ensure timely and effective triage for all women, birthing people and newborns through; enhancements to the telephone triage system at all our sites, timely initial assessment of individuals presenting at triage and timely medical review, if required, with effective oversight and escalation routes. The service will be sufficiently staffed with experienced midwifery and medical staff.
No Delays	Timely access to appropriate treatment and birth setting at all our sites through ensuring; timely procedures for those attending for an elective caesarean section, all women and birthing people are giving birth in suitable setting (birthing suite), timely management and medical care to those sustaining tears during births, timely pain relief to patients requiring it and timely access to theatres for non-elective procedures. The service will be sufficiently staffed with experienced midwifery and medical staff.
Safer Staffing	Support the service's development plan by ensuring that it is sufficiently staffed and underpinned with experienced midwifery and medical staff to appropriately assess and care for women and birthing people and mitigate risks in a timely manner.

Fig1. Workstream Overview

[2] https://www.gov.uk/government/publications/final-report-of-the-ockenden-review

2.5 Highlight reports to demonstrate compliance with action delivery and to outline the success of the actions and improvements to date are generated by each workstream on a weekly basis. The reports are reviewed at the SM MCS Operational Delivery Group (ODG) chaired by the Saint Mary's CEO and submitted for assurance at the Maternity Oversight Group (MOG) chaired by the Group Chief Nurse and Deputy Chief Executive. The MOG is held bi-weekly, membership includes the Midwifery Lead for Midwifery Safety (ICB and Local Maternity and Neonatal System) and members of the Maternity Voices Partnership (MVP).

2.6 The Board of Directors received a report in May 2023 which detailed the agreed measures of success.

3. Progress

3.1. Progress reports have been submitted to the CQC in relation to the compliance action plan on the following dates:

- 27th April 2023
- 15th May 2023
- 26th May 2023

3.2. The submission to the CQC on 26th of May comprised a comprehensive mid-point report detailing progress against the compliance action plan.

3.3. A mid-point review took place on 7th of June with the CQC relationship manager, the Group Chief Nurse, Director of Governance, Deputy Chief Nurse, and members of the Saint Mary's MCS Senior Leadership team and Divisional Leadership team.

3.4. An extraordinary Quality and Performance Scrutiny Committee (QPSC) was convened on 16th of June 2023, enabling SM MCS to provide assurance of the significant improvements made against the concerns raised through the 3 workstreams that were established.

3.5. A final report for the period of the Warning Notice was submitted to the CQC on 23rd June 2023.

3.6. A significant number of the agreed success measures are now visible on and monitored through the SM MCS Maternity and Neonatal Safety Dashboard, providing immediate oversight and supporting monitoring of progress and improvement trends.

3.7. An external review has been undertaken of SM MCS triage services by University Hospitals Coventry and Warwickshire on Monday 5th June 2023. Additionally, Greater Manchester and Eastern Cheshire Local Maternity and Neonatal System (GMEC LMNS) have completed a walk around each of the 3 maternity triage units across SM MCS on 5th June at Wythenshawe, 9th June at North Manchester and 13th June at Oxford Road.

3.8. The Trust received the CQC draft reports following their inspections, these have been reviewed for factual accuracy and submitted to the CQC on 16th June 2023.

4. Patient Safety

4.1 The executive summary of SM MCS dashboard is provided in Appendix 1.

4.2 Since reporting in January 2023 to the Board of Directors there have been three maternal deaths (one per month, February, March and April 2023). The February and March cases have been referred to Healthcare Safety Investigation Branch (HSIB) (the April case did not meet HSIB criteria) and all cases have been referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE). Saint Mary's Maternity and Neonatal Dashboard demonstrates four maternal deaths in a rolling 12-month period. Due to the infrequency of maternal deaths, it is not possible to report special cause variation. Reviews of care provided by SM MCS have not identified any similarities and no harm was attributed to the care SM MCS provided.

4.3 There has been a slight rise in incidents reported with moderate harm or above during April and May 2023, with six incidents reported in May 2023. An analysis of the incidents has been commenced and will be presented to SM MCS Divisional Quality and Safety meeting in July 2023.

5. Ockenden Reports

5.1 The Final Ockenden report[3], published in March 2022 identified **15 IEAs** with 97 separate elements, with progress provided to the Board of Directors bi-monthly. As reported to the Board of Directors in March 2023, a new 'single delivery plan' incorporating the IEAs was expected. NHS England published a three-year delivery plan for maternity and neonatal services on 30th March 2023[4].

5.2 As of 16th April 2023, there are seven outstanding provider led actions (four within Clinical Scientific Services (CSS), two within SM MCS and one at group level) to achieve full compliance with the Final Ockenden report[5].

5.3 Of the seven outstanding actions:

- Three are related to build within Hive which have been delayed due to clinically significant Hive build taking priority. None of the three actions impact on patient safety and builds remain ongoing and are expected to complete by the end of June 2023.
- Three are related to additional obstetric anaesthetic and neonatal consultant staffing required.
- One action relates to involvement of maternity service user representative within the complaints process and has been scheduled into the Patient Experience Team's 2023/24 workstreams/objectives.

[3] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
[4] NHS England » Three year delivery plan for maternity and neonatal services
[5] https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf

6. The Maternity Self-Assessment Tool

6.1 Saint Mary's MCS are committed to complete all actions required within the Maternity Self-Assessment Tool (MSAT)[6], as part of Ockenden IEA's. This has been reported throughout 2022/23 and a further refresh was undertaken in May 2023 as part of the regional assurance in relation to the CQC Warning Notice.

6.2 Currently, within the 168 sections of the 42 actions for SM MCS:

- 160 sections are compliant with all evidence collated
- 5 sections remain in progress and awaiting evidence
- 1 section requires additional evidence to maintain compliance
- 2 sections require evidence from GMEC LMNS

6.3 There are currently five sections awaiting evidence:

- Three sections relate to co-production of Maternity Strategy with Maternity Voices Partnership.
- One relates to maternity guidelines being reviewed against NICE recommendations.
- One relates to a standalone risk management framework for Maternity Services.

7. NHS England three-year delivery plan for maternity and neonatal services

7.1 On 30th March 2023, NHS England released a three-year delivery plan for maternity and neonatal services[7] which asks maternity and neonatal service providers to concentrate on four themes:

- Listening to and working with women and families, with compassion
- Growing, retaining, and supporting our workforce
- Developing and sustaining a culture of safety, learning, and support
- Standards and structures that underpin safer, more personalised, and more equitable care

7.2 SM MCS have undertaken an initial review of the plan, noting the 4 themes are as expected, similar to the themes from both the final Ockenden Report[8] and East Kent Report[9] and include a recommendation to complete the MSAT[10].

7.3 SM MCS 2023/24 continuous improvement plan will address:

- identified actions following receipt of final CQC reports
- any outstanding Ockenden[11] actions
- any outstanding MSAT[12] actions

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6 https://www.england.nhs.uk/publication/maternity-self-assessment-tool/
7 NHS England » Three year delivery plan for maternity and neonatal services
8 https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
9 https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report
10 https://www.england.nhs.uk/publication/maternity-self-assessment-tool/
11 https://www.ockendenmaternityreview.org.uk/wp-content/uploads/2022/03/FINAL_INDEPENDENT_MATERNITY_REVIEW_OF_MATERNITY_SERVICES_REPORT.pdf
12 https://www.england.nhs.uk/publication/maternity-self-assessment-tool/

- all actions generated from SM MCS review of the East Kent Report[13]
- all provider led actions identified in three-year delivery plan for maternity and neonatal services[14]

7.4 The continuous improvement plan will be monitored quarterly at the Maternity and Neonatal Quality and Safety meeting and progress will be provided through SM Quality and Safety Committee (QSC) and onwards to the Board of Directors as part of the Maternity Assurance report.

8. Ongoing assurance reporting to Quality and Performance Scrutiny Committee

8.1 As part of the ongoing monitoring and assurance process, Saint Mary's MCS presented an update of Enhancing Safety Ockenden[15] IEA to the Group Quality and Performance Scrutiny Committee (QPSC).

8.2 Ockenden IEA 4 was submitted to QPSC in June 2023 and demonstrated full compliance. SM MCS will continue to provide IEA updates to QPSC bi-monthly.

8.3 An extraordinary meeting of QPSC occurred on 16th June 2023 to focus on SM MCS improvements in relation to the CQC Section 29A Warning Notice.

9. Maternity Incentive Scheme (MIS) Year 4

9.1 SM MCS submitted full compliance of MIS Year 4 to NHS Resolution on 28th January 2023 and have received confirmation from NHS Resolution of full compliance in June 2023.

9.2 As a continuous reporting requirement:

- The Q4 2022/23 Perinatal Mortality Review report has been provided to Board of Directors board in July 2023.
- The Q4 2022/23 avoidable term admission report is provided to Board of Directors in Appendix 2.

9.3 Year 5 MIS Safety Actions by NHS Resolution on 30th March 2023. The maternity service has commenced work against the updated 10 safety actions. Submission of compliance is required on 2nd February 2024. Regular updates of compliance are planned to be received at SM Quality and Safety Committee. Update positions will be submitted to the Board of Directors in September and November 2023.

Workforce

9.4 Workforce updates are provided monthly on each maternity site, to continually provide staff with accurate information related to recruitment and retention.

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[13] [13] https://www.gov.uk/government/publications/maternity-and-neonatal-services-in-east-kent-reading-the-signals-report

[14] NHS England » Three year delivery plan for maternity and neonatal services

[15] https://www.donnaockenden.com/downloads/news/2020/12/ockenden-report.pdf

9.5 Current vacancies in midwifery establishment are provided in Table 1.

Site	Funded Establishment (WTE)	Vacancy at end of May 2023 (WTE)
Oxford Road	360.13	30.11
North Manchester	173.09	25.29
Wythenshawe	198.94	7.79
Total	**732.16**	**64.19**

Table 1 – Midwifery Vacancies across SM MCS

9.6 Work remains ongoing to reduce vacancies including:

- Proactive recruitment with 137 midwives with job offers in the domestic pipeline:
  - 10 experienced band 6 midwives to join between June and September 2023
  - 127 newly qualified midwives to join between September 2023 and January 2024.

- Proactive international recruitment – 20 in the pipeline
  - 12 in the country
  - 10 OSCE's completed

- A rolling advert to attract midwives has run over the last 12 months, for both general and specialty specific roles. A new recruitment campaign is being launched to attract both experienced and newly qualified midwives.

Training

9.7 Due to the requirements to backfill unexpected sickness and current staffing vacancies, at the end of May 2023 training compliance is below 90% MIS requirements (Table 2).

Site	Core Level 1	Core Level 2/3	MDT Emergency Skills	Fetal Surveillance Training	Neonatal Resuscitation
Oxford Road	93%	80%	83%	84%	91%
North Manchester	88%	72%	71%	78%	76%
Wythenshawe	93%	84%	80%	84%	85%
Total	**90%**	**79%**	**74%**	**83%**	**86%**

Table 2 – Training compliance for SM MCS May 2023 (including MIS Year 4 requirements)

9.8 Training trajectories are in place, with a focus to improve across all sites and staff groups and expected compliance of 90% to be met by the end of September 2023. These are monitored monthly at Divisional Quality and Safety Committee (DQSC), with additional weekly site-based meetings to ensure that there is continued progress.

9.9 The individual staff group compliance is monitored by the Clinical Head of Division (CHoD) and Heads of Midwifery at DQSC, Medical Director and Director of Nursing and Midwifery at SM QSC with oversight by Chief Executive Officer at SM Management Board.

9.10 To mitigate risks associated with non-compliance for training, steps have been taken to ensure those providing intrapartum care maintain compliance with emergency skills, fetal surveillance, and neonatal resuscitation.

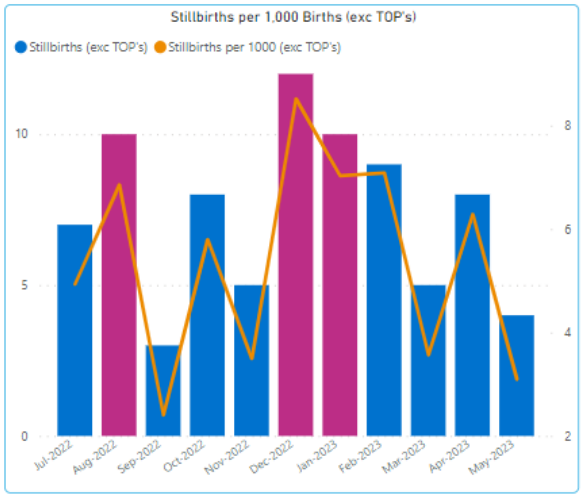
10. Recommendations

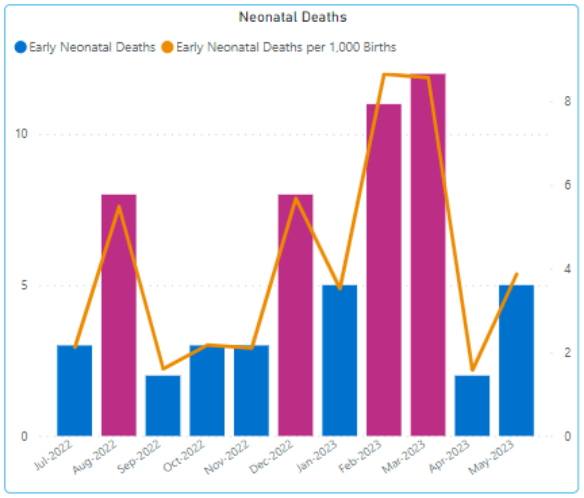
10.1 It is recommended that the Board of Directors:

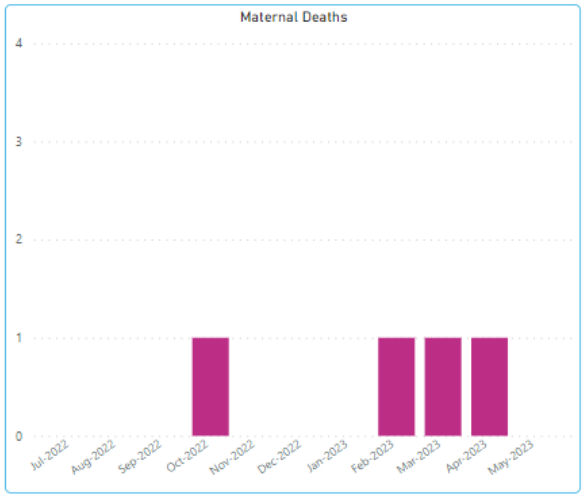
- note the information provided in this report

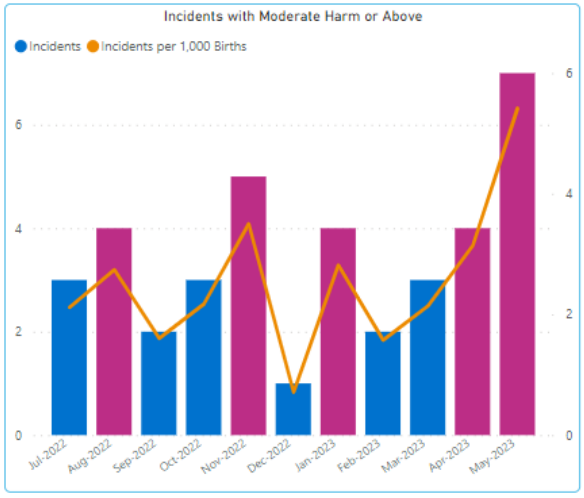
Appendix 1 – Maternity Dashboard

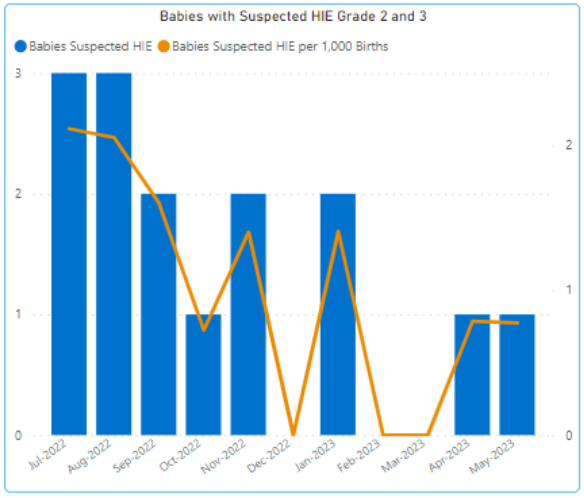
Purple bars indicate Escalations where Actuals are >= Thresholds

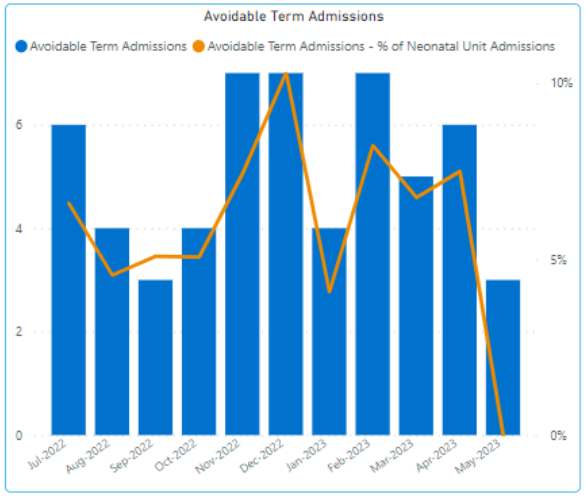












APPENDIX 2

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Saint Mary's Quality and Safety Committee

Report of:	Professor Edward Johnstone, Clinical Head of Division, Obstetrics, Saint Mary's Managed Clinical Service Beverley O'Connor, Sarah Owen and Esme Booth, Heads of Midwifery, Saint Mary's Managed Clinical Service Victoria Bateman, Divisional Director
Paper prepared by:	Jen Sager, Assistant Director of Quality and Safety
Date of paper:	June 2023
Subject:	Quarterly Report of Transitional Care pathway and Avoidable term admissions to Neonatal Unit 1st January to 31st March 2023 (Q4 22/23) as required in Safety Action 3, Year 4 Maternity Incentive Scheme
Purpose of Report:	Indicate which by **(tick as applicable-please do not remove text)** • Information to note • Support • Accept x • Resolution • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	• To improve patient safety, clinical quality, and outcome • Improve the experience of patients, carers, and families
Recommendations:	The Committee is requested to accept and note the details in the report.

Contact:	Name: Jen Sager, Assistant Director of Quality and Safety Email: jen.sager@mft.nhs.uk

1. Background and Purpose

1.1. This paper provides a quarterly update to Board of Directors, as required by Maternity Incentive Scheme (MIS) Year 4 to comply with Safety Action 3 (sections b, e, f and g), and is submitted to Saint Mary's Quality and Safety Committee as part of Saint Mary's MCS perinatal surveillance model, which ensures Maternity, Neonatal and Board level safety champion oversight.

2. Introduction

2.1. ATAIN (Avoiding Term Admissions into Neonatal units) is an NHS England Quality Improvement programme[16] to reduce admission of full-term babies to neonatal care.

2.2. Transitional Care (TC) services support care of vulnerable babies within the maternity setting to reduce avoidable admissions to neonatal services and minimise separation of mothers and their babies.

2.3. It is critical for services to undertake robust reviews and learn lessons to reduce the number of mothers and babies who are separated after birth, and it is on this foundation that audits of TC are included as Safety Action 3 of year 4 MIS.

2.4. Saint Mary's MCS provides transitional care activity on all 3 maternity sites and, in accordance with the British Association of Perinatal Medicine (BAPM) principles, meet the standard set by NHS Resolution Maternity Incentive Scheme Year 4.

2.5. Saint Mary's MCS have a single harmonised Saint Mary's MCS TC guideline which was jointly developed by maternity and neonatal teams. This meets MIS year 4 Safety Action 3 (section a).

3. Audits of Transitional Care (TC) provision for 1st January to 31st March 2023 (Q4 22/23)

3.1. As required by Year 4 MIS Safety Action 3, this quarterly review details the number of admissions to the neonatal unit which met current TC admissions criteria but were admitted to the neonatal unit due to capacity or staffing issues or were admitted to, or remained on NNU, because of their need for nasogastric tube feeding.

3.2. There were no babies, who met current TC admission criteria, admitted to the neonatal unit in Q4 2022/23 because of not receiving transitional care due to staffing or capacity issues.

3.3. There were three babies, who met current TC admission criteria, admitted to the neonatal unit in Q4 2022/23 requiring of nasogastric tube feeding, and all occurred at Saint Mary's North Manchester. Actions to implement full transitional care pathways

[16] https://www.england.nhs.uk/wp-content/uploads/2021/03/reducing-harm-leading-to-avoidable-admission-of-full-term-babies-into-neonatal-units-summary.pdf

at North Manchester and Oxford Road are ongoing with progress provided in Appendix 1.

3.4. The COVID-19 pandemic has not changed the provision of TC across the Saint Mary's MCS during Q4 2022/23.

3.5. In addition, SM MCS also audit all transitional care activity to capture current capacity and demand for transitional care and capture Healthcare Resource Groups (HRG) 4/XA04 activity.

3.6. Quarterly TC activity audits are provided to SM MCS Neonatal Safety Champion for all 3 sites and meets MIS Year 4 (sections b, d and e) requirements.

3.7. There remain difficulties in extracting HRG 4/XA04 activity data to support TC activity from the Electronic Patient Record (EPR) system. As such, the audit for Q4 have used both Hive data and manual data to complete Q4 reporting. It is expected this will be resolved and from Q1 23/24 will use only data extracted from Hive,

4. Review of term admissions to the Neonatal Unit using the Avoiding Term Admissions In to Neonatal units (ATAIN) framework

4.1. The ATAIN programme aims to reduce admissions to the Neonatal Unit by identifying and acting upon practice issues promptly to demonstrate improvements in care. Focusing on:

- Respiratory conditions
- Hypoglycaemia
- Jaundice
- Asphyxia (perinatal hypoxia-ischaemia)
- Hypothermia

4.2. Documentation audits occur monthly by ATAIN champions and compliance is monitored on a quarterly basis at Maternity Services Divisional Quality and Safety meeting. This meets MIS year 4 Safety Action 3 (section c).

4.3. A weekly multidisciplinary review of unexpected admissions to the neonatal unit occurs on each maternity site, highlighting themes, actions, learning and whether the admission could have been avoided. This meets MIS year 4 Safety Action 3 (section f).

4.4. In the period 1st January to 31st March 2023, there were 19 term admissions across Saint Mary's MCS which were considered avoidable following multidisciplinary review. 7 babies on the Oxford Road site, 6 babies on the Wythenshawe site and 6 babies on the North Manchester site.

4.5. The Avoidable Admissions to Neonatal Unit report for Q4 2022/2023, including themes for each avoidable admission and lessons learned, is monitored quarterly at Site Obstetric Quality and Safety Committee.

4.6. On review of specific ATAIN metrics above in 4.1, of the 19 avoidable admissions to the Neonatal Unit:

- 1 baby was admitted due to respiratory conditions
- 1 baby was admitted due to hypoglycaemia
- 0 babies were admitted due to early onset jaundice

- 0 babies were admitted due to perinatal hypoxia-ischaemia
- 1 baby were admitted due to hypothermia

4.7. None of the reviews identified an increase in term admissions for the 5 ATAIN metrics (see 4.1), during Q4 2022/23.

4.8. Themes identified outside of those metrics in 4.1 include:

- Not following guidance/policy (sepsis, NNU admission criteria, escalation)
- NG tube feeding not available
- Appropriateness of fetal monitoring, CTG interpretation and escalation

4.9. The maternity and neonatal dashboard has not identified individual site variation during Q4 2022/23. The overall numbers of avoidable term admissions are static as demonstrated below in Fig1 at approximately 7% in Q3 and Q4 2022/23.

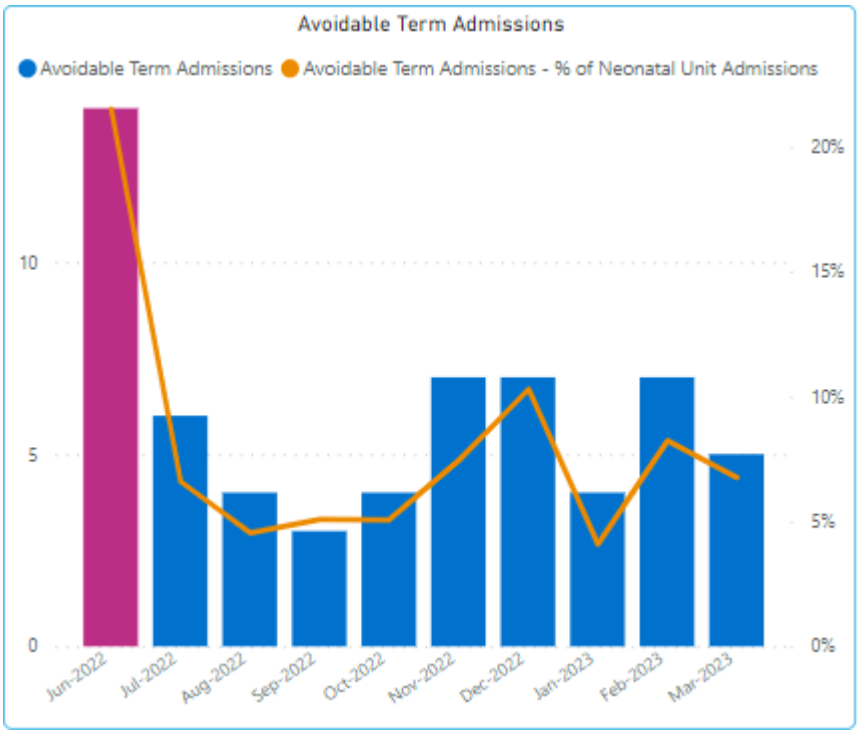


Fig1. Avoidable Term Admissions to Neonatal Unit Jan to Mar 23 (Q4) across all 3 maternity sites.

4.10. Each review, where required, continues to generate specific actions and these are logged via the risk management system, and monitored at the Site Obstetric Quality and Safety Committee.

4.11. Further scrutiny is then applied monthly at the Divisional Quality and Safety Committee.

5. Action Plan

5.1. An overall ATAIN action plan (Appendix 1), as required by MIS year 4 Safety Action 3 (section g) is in place with the progress on harmonisation of TC model and review of increased avoidable admissions now included.

6. Conclusion

6.1. Following approval at SM MCS Quality and Safety Committee, this paper will be submitted to the Board of Directors for Manchester Foundation Trust as part the Maternity Assurance report in July 2023.

6.2. In accordance with the perinatal surveillance model, following approval, this paper will be shared with Greater Manchester and Eastern Cheshire Local Maternity System (GMEC LMS) and onwards to Integrated Care Board (ICB). This meets MIS year 4 Safety Action 3 (section h).

6.3. Saint Mary's MCS has maintained full compliance during Quarter 4 of 2022/2023. Appendix 2 provides clear overview of compliance of MIS Year 4 Safety Action 3.

Appendix 1 of ATAIN

Action plan for MIS Safety Action 3 – Reviewed June 2023

	Action	Lead	By When	Status
1	Harmonise Transitional Care model across Saint Mary's MCS	Neonatal Matron and Inpatient Matron at North Manchester to work with Lead Nurse for Newborn Service to fully implement TC model	December 2022 Extended to December 2023 to support workforce review	Full workforce review has been completed which has identified a NN staffing gap to implement TC. A business case is required for TC model at North Manchester. Work is ongoing with the Newborn Services division and overseen by Head of Nursing for Newborn Services. A paper is being prepared to support this requirement. SM MCS is committed to implement full TC pathway during 2023. The training and preparation to commence NG Tube feeding is underway and will launch on PNW at ORC at end of July 2023.
2	Harmonise Transitional Care Guidance across Saint Mary's MCS	Lead Nurse for Neonatal Service and DHoM's to lead in harmonisation of TC guideline on all sites	June 2022 extended to July 2022	Completed July 2022
3	Full review of themes for admission to NNU at Wythenshawe	Lead Midwife for Governance, DHoM Wythenshawe, Clinical Director Wythenshawe	August 2022	Completed August 2022.

Appendix 2 of ATAIN

Indicator/ standard Safety Action 2	Compliant Yes/No
a) Pathways of care into transitional care have been jointly approved by maternity and neonatal teams with a focus on minimising separation of mothers and babies. Neonatal teams are involved in decision making and planning care for all babies in transitional care.	Yes
b) The pathway of care into transitional care has been fully implemented and is audited quarterly. Audit findings are shared with the neonatal safety champion, LMNS, commissioner and Integrated Care System (ICS) quality surveillance meeting each quarter.	Yes
c) A data recording process (electronic and/or paper based for capturing all term babies transferred to the neonatal unit, regardless of the length of stay, is in place.	Yes
d) A data recording process for capturing existing transitional care activity, (regardless of place - which could be a Transitional Care (TC), postnatal ward, virtual outreach pathway etc.) has been embedded. If not already in place, a secondary data recording process is set up to inform future capacity management for late preterm babies who could be cared for in a TC setting. The data should capture babies between 34+0-36+6 weeks gestation at birth, who neither had surgery nor were transferred during any admission, to monitor the number of special care or normal care days where supplemental oxygen was not delivered.	Yes
e) Commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data set (NCCMDS) version 2 are available to be shared on request with the operational delivery network (ODN), LMNS and commissioners to inform capacity planning as part of the family integrated care component of the Neonatal Critical Care Transformation Review and to inform future development of transitional care to minimise separation of mothers and babies.	Yes
f) Reviews of babies admitted to the neonatal unit continue on a quarterly basis and findings are shared quarterly with the Board Level Safety Champion. Reviews should now include all neonatal unit transfers or admissions regardless of their length of stay and/or admission to BadgerNet. In addition, reviews should report on the number of transfers to the neonatal unit that would have met current TC admissions criteria but were transferred or admitted to the neonatal unit due to capacity or staffing issues. The review should also record the number of babies that were transferred or admitted or remained on Neonatal Units because of their need for nasogastric tube feeding but could have been cared for on a TC if nasogastric feeding was supported there. Findings of the review have been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting quarterly.	Yes
g) An action plan to address local findings from the audit of the pathway (point b) and Avoiding Term Admissions Into Neonatal units (ATAIN) reviews (point f) has been agreed with the maternity and neonatal safety champions and Board level champion.	Yes
h) Progress with the revised ATAIN action plan has been shared with the maternity, neonatal and Board level safety champions, LMNS and ICS quality surveillance meeting	Yes

Agenda Item 11.4

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Tanya Claridge, Acting Director of Clinical Governance
Date of paper:	July 2023
Subject:	Risk Management Framework and Strategy 2022-25: Updated
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval • Ratify ✓
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Trust's Risk Management Framework and Strategy underpins the delivery of, and assurance processes related to the Trust's Vision, Values and Strategic Aims.
Recommendations:	The Board of Directors is asked to note the work undertaken through the Group Risk Oversight Committee to update the RMFS following its annual review and the outcome of an internal audit received in relation to the effectiveness of the controls in place The Board of Directors is asked to ratify the Trust's updated Risk Management Framework and Strategy 2022-2025
Contact:	Name: Dr Tanya Claridge, Acting Director of Clinical Governance Tel: 0161 276 5930

DOCUMENT CONTROL PAGE

Title:	Risk Management Framework and Strategy 2022-2025
Version:	**2**
Supersedes:	Version 1
Application:	Trust-wide

Originated /Modified By:	Dr Tanya Claridge
Designation:	Acting Director of Clinical Governance
Ratified by:	Board of Directors
Date of Ratification:	

Issue / Circulation Date:	
Circulated by:	
Dissemination and Implementation:	
Date placed on the Intranet:	

Planned Review Date:	July 2024
Responsibility of:	Director of Clinical Governance

Minor Amendment (If applicable) **Notified To:**	Inclusion of revised Principal Risks (7.4) Update in relation to outcome of annual review/ Internal audit-Risk de-escalation (6.15, 6.22), risk review frequency (6.19., 6.22, 6.26). Role of IGRC (minor) (Appendix 2)
Date notified:	**10/7/23**

EqIA Registration Number:	28/10R

RISK MANAGEMENT FRAMEWORK AND STRATEGY

2022-2025

Version 2 (2023)

Contents

1. Introduction

1.1. Manchester University NHS Foundation Trust (the Trust) has a clearly articulated vision, '*to improve the health and quality of life of our diverse population by building an organisation that excels in quality, safety, patient experience, research, innovation and teaching; attracts, develops and retains great people and is recognised internationally as a leading healthcare provider'*

1.2. The Trust recognises that in working to achieve that vision, providing a wide range of clinical services, across multiple hospital sites, managed clinical services (MCS) and Local Clinical Organisations (LCOs), the activities associated with employing staff, providing premises and managing finances are an inherently risky undertaking, but that risk, properly managed can bring with it advantages, benefits and opportunities. This is because understanding risks and managing them appropriately will result in better decisions, support the effective delivery of strategic objectives and enable improvements in clinical quality and performance.

1.3. Risk influences every aspect of the Trust's day-to-day clinical operations and non-clinical business, and the continued delivery of high-quality care requires the identification, management and minimising of events or activities which could result in unnecessary risks to patients, staff and visitors/members of the public.

1.4. The continued changes in the healthcare environment, increasing competition and the increased regulatory and statutory requirements create considerable challenge, uncertainty and opportunity.

1.5. Authorisation as a foundation trust requires strategic business risk management, in addition to the management of the risks associated with the delivery of clinical services. Maintaining Foundation Trust status is dependent on regular 'self-certification' by the Trust Board that clinical service, governance and financial standards are met. In turn, self-certification requires access to high quality risk and assurance reports that are the product of an effective risk management strategy.

1.6. Risk management activities undertaken within the Trust operate at a number of levels: for example, a health or social care professional creating a risk management plan for a patient; corporate planning around the organisational response to a major incident and risk assessment and mitigation for business expansion and development.

1.7. Therefore, the management of risk is a key organisational responsibility and is the responsibility of all staff employed by the Trust. Risk management is an integral part of good clinical and corporate governance, and the Trust has adopted an integrated approach to the overall management of risk irrespective of whether the risks are clinical or non-clinical. Risk management

is therefore embedded within the Trust's overall performance management framework and links with business planning and investment decisions.

1.8. This document describes how the Trust's strategy and its related procedures and protocols (detailed in the Trust's Risk Management Handbook) serve to set these various risk management activities within a broader corporate framework ensuring a consistent approach to risk management across the Trust.

2. Statement of Intent

2.1. Manchester University NHS Foundation Trust ('the Trust') is committed to ensuring that risk management is aligned to strategic objectives, clinical strategy, business plans and day to day operational management systems.

2.2. The Trust recognises that the specific function of risk management is to identify and manage risks that threaten our ability to achieve our strategic objectives. It is clear, therefore, that understanding and responding to risk, both clinical and non-clinical, is vital to making the Trust a safe, effective and reliable organisation.

2.3. The Trust acknowledges that in delivering health improvements and in embracing positive advantages risks may need to be taken. The Trust recognises that it cannot create a risk-free environment, but rather one in which risk is considered as an integral part of everything it does and is appropriately identified and controlled.

2.4. The Trust therefore identifies risk as either an opportunity or a threat, or a combination of both, and will assess the significance of risk as a combination of probability and consequences of the occurrence.

2.5. All staff have a responsibility for identifying and minimising risk. This will be achieved within a progressive, honest and open culture where risks, system variability and incidents are identified quickly and acted upon in a positive way.

2.6. This document describes the Trust's Risk Management Framework and Strategy for 2022-2025.

3. Scope and Objectives

3.1. This document provides the overarching strategic approach to risk management and the framework within which risk is managed by the organisation. It is fully endorsed by the Trust Board. The Board consider it a contemporary strategy and is assured through the work of the Group Risk

Oversight Committee that it reflects currently available information, guidance and legislation governing the NHS.

3.2. This Risk Management Framework and Strategy has been developed aligned to the Trust's Vision and Values, and in particular the values and behaviour framework.

3.3. This Risk Management Framework and Strategy is designed to strengthen the Trust's ability to achieve its Strategic Objectives and business targets and therefore ensuring the continuation of the safe, effective and responsive delivery of services.

3.4. It will do this by detailing the risk management processes and associated infrastructure to enable the Trust to:

- Actively pursue the identification of uncertainties in order that threat can be mitigated, and opportunity utilised
- Continue to develop a mature risk aware and safety culture
- Ensure that a consistent and integrated approach to risk management is embedded in the day-to-day working practices of the organisation at all levels, embracing clinical, non-clinical and corporate risks
- Ensure that the risk management process covers the full range of the Trust activities
- Continue developing the systems and structures in place for identifying, assessing, escalating and recording risk
- Optimise its approach to assurance throughout the Trust
- Make effective use of information from risk assessments, and multi-source intelligence, for instance in relation to system variability, incidents, complaints, audit, claims, effective implementation of external recommendations and other external sources (including HM Coroner and regulators) to improve quality and support organisational learning
- Ensure that the Governors, Board and senior management are provided with adequate assurance that risks are being appropriately identified, assessed, and mitigated
- Demonstrate compliance with legal and regulatory compliance. The Trust operates within a complex regulatory framework and all regulators require a consistent and comprehensive approach to ensuring adherence risk management standards (for instance NHS England/NHS Improvement (NHS E/I) the Care Quality Commission (CQC), the Health and Safety Executive (HSE))
- Use Internal Audit effectively to provide independent assurance in relation to the effectiveness of controls in place to manage risk.

4. Types of risk exposure

4.1. The Trust is exposed to a wide range of risks which can be categorised within a taxonomy. As part of demonstrating compliance with its Provider Licence, the Board must self-certify that risks identified in these areas are being

successfully mitigated, or else declare non-compliance and develop an action plan where this is not the case.

4.2. The risk categories are as follows (and can be mapped to the Board Assurance risks described in section 7.4):

4.2.1. **Quality, Governance and Performance Risk:** This covers risks to compliance with the Trust's licence and includes third party investigations that could suggest material issues with governance e.g., CQC concerns, fraud, CQC reviews, planned or unannounced, and its outcomes / findings and other patient safety issues which may impact compliance with the Provider licence (e.g. serious incidents, complaints)

4.2.2. **Continuity of Services Risk**: This encompasses risks to the Trust being able to provide ongoing availability of key services. For example, future transactions potentially affecting the continuity of services risk rating or the risk of a failure to maintain registration with the CQC for Commissioner Requested Services (CRS)

4.2.3. **Information Security Risk:** This is the potential for unauthorised use, disruption, modification or destruction of information assets. Information is a vital asset, both in terms of the clinical management of individual patients and the efficient management of services and resources. Without effective cyber security, incidents can threaten health, breach privacy, disrupt business continuity, damage assets and facilitate other crimes such as fraud. The Trust has a legal obligation to ensure that appropriate security management arrangements are in place for the protection of data.

4.2.4. **Operational Risks:** These are risks concerned directly with the operational activity of the Trust. This category of risk would, therefore, include sub-divisions such as performance, workforce, health and safety, security and fire.

4.2.5. **Financial Risk:** This encompasses risks arising from financial planning and management and includes credit risk, market risk, liquidity risk, budget risk, accounting risk, fraud risk etc. It would also include requirements for additional working capital facilities, failure to comply with the statutory reporting guidance and an adverse report from internal or external auditors or any independent review.

4.2.6. **Business Risk:** The Trust is also exposed to commercial risks as a result of operating in a dynamic and competitive health and social care market. Within this environment the Trust faces risk from loss of referrals or contracts, changes in commissioner strategy or procurement actions, threats arising from major transactions such as mergers and acquisitions, and loss of business through patient choice.

4.2.7. **Reputational Risk**: This encompasses current or prospective risk arising from the adverse perception of the image of the Trust by commissioners, partners, individuals, the local community or regulators. Consideration of how clinical and non-clinical risks may adversely affect the Trust's reputation should be made as part of the overall assessment of a risk at its initial assessment and following mitigation when

considering residual risk.

5. Risk appetite

5.1. The Trust understands risk appetite as a mechanism to translate risk metrics and methods into decisions, reporting and the day-to-day business of the Trust and that it provides a framework linking corporate strategy, target setting and risk management. Risk appetite is the amount of risk that any organisation is prepared to accept, or tolerate, or be exposed to at any point in time, and every risk needs to be assessed for the acceptable level of risk appetite.

5.2. On an annual basis the Trust's Board of Directors, through the work of the Group Risk Oversight Committee, will confirm its risk appetite statement. The risk appetite statement will be generated from a formal discussion and will focus on the key categories of risk as described in Section 4 and supported by the application of a Risk Appetite Matrix for NHS organisations (See Appendix 1). The Board's risk appetite, as detailed in the statement, will be aligned to the Trust's Strategic Objectives to support integration into the Board Assurance Framework (See Section 6)

5.3. In addition to the Risk Appetite Statement, the Trust will also express its risk appetite through:

5.3.1. **A standardised approach to identifying a potentially unacceptable level of risk:** As described in Section 6, the Trust will use a 5 x 5 matrix (likelihood and consequence) to identify risk ratings. The Trust has set a boundary on the risk matrix, the 'risk appetite line' which is set at 15. Any risks rated at or above this level are escalated for consideration at the Group Risk Oversight Committee (See Section 7), and directly influence the assurances contained within the Board Assurance Framework (See section 6). A risk score of 15 or above is therefore treated as a trigger for a discussion as to whether the Trust is willing to accept this level of risk.

5.3.2. **Target risk ratings:** Target risk ratings should be set for all risks. This risk rating is a means of expressing a target for the highest acceptable (tolerated) level for that risk. When setting target risk ratings, risk leads should consider what level of tolerated risk they are willing to retain. For some risks, the target risk rating could be high, especially where the consequences are potentially severe, or some elements of the risk lie outside the direct control of the Trust.

5.3.3. **Risk Appetite rating:** All risks will have a risk appetite rating which will be derived from the Risk Appetite Matrix for NHS organisations (see Appendix 1).

6. Implementing Risk Management Trust-wide

6.1. Integrated risk management is a process through which organisations comprehensively identify, assess, analyse and manage all risks and incidents.

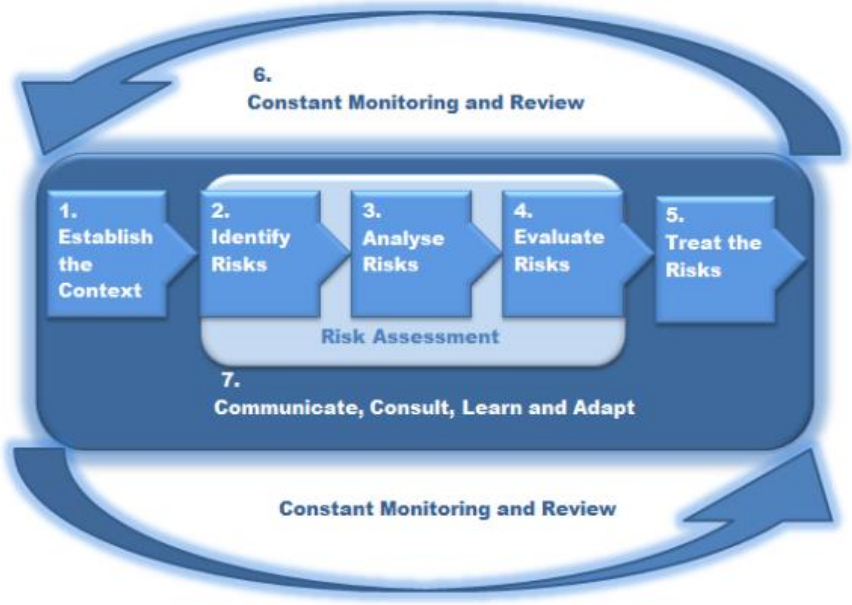
6.2. Risk management across the Trust is supported by a range of organisational policies and procedures, and the Trust's Risk Management Handbook provides operationally focused detail and advice particularly in relation to risk assessment, action planning, monitoring, review and identifying assurance.

6.3. Risk management is used to:

- Identify potential risks with the intention of initiating and monitoring action to prevent or reduce the adverse effects of risks
- Manage the treatment of risk in a systematic way so that the organisation can determine acceptability of residual risks
- Provide a comprehensive approach to improving patient and staff safety
- Improve decisions about resources and priorities
- Provide information to the Board through the committee governance infrastructure structure so that it can make informed decisions

6.4. The risk management process is illustrated in Figure 1.

Figure 1: The Risk Management Process



Establish the Context

6.5. This Risk Management Framework and Strategy serves to establish the external, internal and risk management context in which the rest of the

process will take place. The Trust's Risk Management Handbook provides details of the established criteria against which risk will be evaluated and the structure of the analysis is defined within the Trust's Electronic Risk Management System and explained in the Trust's Risk Management Handbook.

Risk assessment

6.6. The formal method of identifying and understanding risks within the Trust is using risk assessments.

6.7. A risk assessment is the systematic identification, assessment and evaluation of anything that can interfere with the delivery of the highest standard of service and working environment within the Trust. The Trust's Risk Management Handbook provides a practical guide to risk assessment.

Risk identification

6.8. The Trust takes both proactive and reactive approaches to identifying and understanding risk.

6.9. The Trust will take steps to proactively identify risk by using a range of information sources, including, but not limited to audit outcomes, patient and staff survey, external enquiries, CQC intelligence, and horizon scanning, identifying, evaluating and managing changes in the risk environment locally (e.g. socio economic trends), nationally (e.g. legislation) and internationally (e.g. public health intelligence). More information about sources used for proactive identification of risk are detailed in the Trust's Risk Management Handbook.

6.10. The Trust has a range of sources of intelligence about areas of actual and emergent risk within the organisation. These include a patient safety management system, an Accountability Oversight Framework and benchmarked Trust-wide performance indicators (for instance within the Model Hospital)

Risk Analysis

6.11. Determining the relative importance of individual risks is a key element of the risk management process, enabling risk control priorities to be identified and appropriate action to be taken in response. All risks identified are graded using a common grading matrix (see figure 2), which measures the risk in terms of both consequence and likelihood. This is achieved by:
A: Assigning a score to the 'likelihood' of a risk event occurring
B: Assigning a score to the 'severity' or 'impact' of the consequences of the risk event
C: Identifying the risk rating via a risk matrix (5X5). The risk rating is calculated as the likelihood (probability or frequency) X severity of consequence.

6.12. The Trust's Risk Management Handbook describes in detail the approach to grading in the Trust and describes the approach to the validation of risk assessment outcomes

Figure 2: Risk Matrix					
Consequence (B)	**Likelihood (A)**				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic	Score 5	Score 10	Score 15	Score 20	Score 25
4 Major	Score 4	Score 8	Score 12	Score 16	Score 20
3 Moderate	Score 3	Score 6	Score 9	Score 12	Score15
2 Minor	Score 2	Score 4	Score 6	Score 8	Score 10
1 Negligible	Score 1	Score 2	Score 3	Score 4	Score 5

Risk evaluation and escalation/de-escalation

6.13. Risk evaluation involves the comparison of estimated levels of risk against the pre-established criteria (See Figure 3). This enables risks to be ranked to support the identification of management priorities. Risk evaluation should always be undertaken directly considering the risk appetite for that area of risk.

Figure 3: Risk Evaluation: Risk level, tolerance, action and escalation			
Risk level	Score	Actions	Required Oversight
Low	1-3	Managed through normal local control measures.	Managed at local level
Moderate (Acceptable risk threshold)	4-6	Review control measures through formal risk assessment. Entered on Risk Register	Managed at service level
High	8-12	Review control measures through formal risk assessment. Treatment plans to be developed, implemented and monitored Entered onto Risk Register	Managed at Hospital Site/Managed Clinical Service/LCO or Corporate level through local risk escalation framework
Extreme	15-25	Review control measures through formal risk assessment. Treatment plans to be developed, implemented and monitored Immediate actions required to reduce risk Entered on to Risk Register	Managed at: Executive Chaired Assurance Committees Group Risk Oversight Committee Relevant Scrutiny Committees (For Executive and Non-Executive Director scrutiny and oversight)

6.14. **Risk tolerance** is the acceptable level of variation relative to the achievement of an individual objective. It is the amount of risk to which a

programme or an activity is prepared to be exposed to or that its resources allow it to be exposed to before actions become necessary.

6.15. The Trust has set its tolerance threshold for acceptable risk as moderate. This threshold is set in expectation of what risks are likely to be actually realised and the resources needed to realistically control them. The Trust has an established framework (See Figure 3) to support the escalation of risks that exceed the threshold of acceptable risk and the de-escalation or risks that have reached the tolerated risk level

6.16. If the levels of risk established are low (1-3), then risks may fall into an acceptable category and treatment may not be required, however action should always be taken to reduce risks unless this involves measures that are clearly disproportionate in relation to the risk.

6.17. At or below the tolerance threshold all risks are monitored and evaluated within hospital sites, Managed Clinical Services, the Local Care Organisation, within a Single Hospital Service or Corporate departments on an on-going basis to confirm and reassess their rating. All risks at, or above this threshold (throughout the organisation) are actively managed and mitigating actions taken to bring the risk back into tolerance.

6.18. All risks graded at 12 or above, meaning that a major outcome is possible, and a moderate outcome is likely are escalated for consideration and oversight at Hospital Site, Managed Clinical Service or Local Care Organisation Risk Committees and Hospital Management Boards and within the senior management infrastructure corporately, including at Trust-wide Boards or Committees with a specific focus. These risks are known as corporate risks.

6.19. A progress update of each of these risks should be made available to the relevant monitoring structure at each meeting and subject to at least 6 monthly detailed scrutiny. In addition, if, during the dynamic review of the risks it is identified that there has been a change in the exposure (a change in controls, for instance through the completion of planned actions), these should be presented for consideration at the relevant meeting in an exception report. If the risk exposure has been successfully reduced and the management of the risk no-longer reaches the threshold, then the risk should be de-escalated for monitoring aligned to the structure presented in Figure 3, with the decision recorded formally in minutes.

6.20. Corporate risks are used to contextualise the assurances within the Board Assurance Framework and to provide an analysis of quantum of strategic (where corporate risks are linked to strategic risk and have an impact on their effective mitigation (See Section 7)). These risks can also, at the discretion of the senior management infrastructure described above, be escalated individually for consideration by the Group Risk Oversight Committee, if it is assessed that the impact of the risk on achievement of a

strategic objective is potentially significant, for instance in relation to its interdependency with another risk.

6.21. All risks graded at 15 or above where a catastrophic outcome is possible, a major outcome is likely, or a moderate outcome is certain are escalated for consideration in relation to the achievement of the Trust's strategic objectives at the Group Risk Oversight Committee as the effectiveness of the mitigation in place in relation to these risks is likely to directly influence the assurances within the Board Assurance Framework (see Section 7). These are strategic risks

6.22. A brief progress update of each of these risks should be made available to the Group Risk Oversight Committee (in the routine 'risk exposure report') at each meeting and subject to at least 6 monthly detailed scrutiny. In addition, if, during the dynamic review of the risks it is identified that there has been a change in the exposure (a change in controls, for instance through the completion of planned actions), these should be presented for consideration at the relevant meeting in an exception report. If the risk exposure has been successfully reduced and the management of the risk no-longer reaches the threshold, then the risk should be de-escalated for monitoring aligned to the structure presented in Figure 3, with the decision recorded formally in minutes of the meeting.

Treat the risk

6.23. In planning the response to or 'treatment' of an identified risk, the following principles should be considered:

- Balancing relative risks; where the management of one risk adversely effects the management of another risk or increases the rating of that risk, a decision will be required about proceeding with planned controls based on the significance of each risk
- Avoiding creating a risk from controlling a risk; establishing controls and mitigations for one risk may in itself create a different or new risk and measures should therefore be assessed for their unanticipated consequences
- Ensuring mitigation/control is proportionate to risk; proportionality will include time, effort and resources balanced with the overall rating and significance of the risk being managed
- Paying attention to changes in risk ratings, and ensuring regular reviews of ratings and controls, while the level of risk will determine its priority the focus should not solely be on high and extreme risks
- Aligning risk management with the development and implementation of policies and procedures; policies and procedures should anticipate and address risks and should form part of the controls and assurance for mitigating and removing risks. Similarly, development or review of policies should identify the risks they are in place to mitigate or remove

- The consequences of a risk occurring will generally stay the same, any treatment of the risk is designed to reduce the likelihood of the risk materialising

6.24. The Trust recognises that it may be necessary to accept a risk, for example, if no further mitigation is possible or if there is an appetite for taking a risk because of the perceived benefits of doing so. The decision as to whether a risk can be accepted should be made based on the appetite for acceptance and agreed according to the risk escalation framework (see Figure 3). All risks of ≥15 that are accepted must be reviewed and reported to the Group Risk Oversight Committee at least every 12 months or additionally in the event of any changes to the risk score or controls.

6.25. The Trust's Risk Management Handbook provides information about risk treatment and approaches to assuring the effectiveness of actions taken to mitigate the risk.

Risk Monitoring

6.26. Risks must be systematically and dynamically monitored and reviewed. Risks are constantly changing and therefore effective control of risk can only be achieved with contemporaneous information on the risks, the controls in place and the provision of evidence that the controls are managing the risk as anticipated.

6.27. Strategic risks (risks graded at 15 or above, where a catastrophic outcome is possible, a major outcome is likely, or a moderate outcome is certain, or any risks that have been determined to have a direct impact on the delivery of Trust strategic objectives) should be reviewed at least bi-monthly and reported in an oversight report to the relevant oversight Committee at each meeting. The oversight Committee should determine the requirement for scheduled detailed reviews.

6.28. Corporate risks (those risks escalated for oversight by Site/MCS/LCO should be reviewed bi-monthly and reported in an oversight report to the relevant Committee, the oversight Committee should determine the requirement for scheduled detailed reviews,

6.29. All other risks should be formally reviewed at least 6 monthly, the nature of the work of the organisation determines that review should be dynamic for instance with consideration given to the impact on new emerging risks to existing risks.

6.30. All risks that require active and monitored mitigation should be recorded on the Trust's risk register (See the Trust's Risk Management Handbook for details relating to this process).

6.31. The risk register provides the means of describing, scoring and ranking risks. It identifies ownership, controls in place, the need for further reduction and the recording of additional controls that are to be put in place. The overall aim of the risk register is not to document all the risks faced by the Trust, but the more significant ones and to record the action plans to mitigate those risks to acceptable levels.

6.32. All records of risk assessments on the Trust's Risk Register should include specific components (See Figure 4) which support the documentation of the severity of the risk and the likelihood of it occurring in order, taking account of the **'existing controls'** to identify the **'initial'** risk score and also the '**residual'** risk score, which is what the score will decrease to following implementation of '**planned actions'**. In addition, the risk assessment should include a **'target'** score (see 5.3.2).

Figure 4: Specific Components of a risk assessment	
Component	**Assessment information sourced from**
Initial Risk	Risk and Control Self-Assessment Key Risk Indicators
Existing Controls	Risk and Control Self-Assessment Key Control Indicators Controls assurance
Planned actions	Designed to add new control and mitigation measures
Residual Risk	Risk and Control Self-Assessment Residual risk Key Risk Indicators Risk Incidents
Target Risk	Based on risk appetite, the level of risk the Trust wants to take, and what level of risk is acceptable.

6.33. The Trust's risk register therefore provides a Trust-wide database of all risks faced by the organisation, categorised by their risk score, their combined consequence and likelihood. This is an invaluable source of information for the Trust and supports the effective escalation of significant risks aligned to the Trust's risk tolerance (See 6.14).

6.34. The Trust's Risk Management Handbook provides standard operating procedures for the management of the Trust's Risk Register at service, organisation and corporate levels, providing explicit guidance in relation to the management and escalation of risks with a potential Trust-wide impact, or those relating to a Single Hospital Service.

Communicate and consult, adapt and learn

6.35. The Trust is committed to communicating and consulting about risk widely, including with external stakeholders as appropriate, at each stage of the risk management process.

6.36. The Trust has established an Integrated Governance and Risk Committee to support the optimising and integration of transferable learning from the management of risk across the Trust.

7. Strategic Risk and Assurance

7.1. Boards of all provider organisations are required to ensure there is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks to the achievement of their strategic objectives. The purpose of the Board Assurance Framework (BAF) is to bring together all the risks the organisation faces that threaten its ability to achieve its strategic objectives together with objective evidence and assurance of how those risks are being mitigated.

7.2. The BAF document identifies the strategic objectives, the risks in achieving those objectives, the level of risk, source and quality of assurance, and a high-level position statement. The document is structured to satisfy the requirements of Trust regulators and supports the Annual Governance Statement.

7.3. The Trust's Risk Register is structured to allow risks to be linked (for instance risks being managed within a Hospital Site, Managed Clinical Service, Local Care Organisation or corporately that are related to risks that have been escalated for strategic oversight) and contextualised within a principal risk infrastructure.

7.4. All risks are analysed and themed into a suite of principal risks, aligned to the Trust's strategic objectives these principal risks are categorised as follows: There is a risk that the Trust experiences a:

1. Failure to maintain essential standards of quality, safety, and patient experience
2. Failure to improve operational performance
3. Failure to meet regulatory expectations, and comply with laws, regulations, and standards
4. Failure to effectively address issues affecting staff experience
5. Failure to effectively plan for, recruit, and retain a diverse workforce with the right skills
6. Failure to implement and embed infrastructure plans including digital and estates
7. Failure to embed the Trust's approach to value and financial sustainability
8. Failure to work with system partners to address health inequalities, and deliver social value and sustainability

9. Failure to expand MFT's research and innovation capability and capacity
10. Failure to deliver the required transformation and integration of services

7.5. The Board Assurance Framework is an interactive tool and used throughout the governance of the organisation to support risk and assurance processes. It is considered by the Board of Directors tri-annually.

8. Accountability and Responsibility: Board and Committee Governance

8.1. The Trust has an established Board and Committee governance framework that supports the implementation of this strategy. A summary of the key elements of the Governance Framework is provided in Appendix 2.

8.2. In brief, the Group Board of Directors is accountable for the delivery of this risk management strategy and has a collective responsibility to ensure that the risk management processes provide adequate and appropriate information, and assurances relating to risks which threaten the achievement of the Trust's strategic objectives. The Board is required to approve an annual self-certification confirming that risk management systems are effective and fit for purpose. This self-certification includes an assessment of risks which could adversely affect the terms of Trust authorisation.

8.3. This accountability is underpinned by a committee and governance infrastructure that is designed to provide both effective and proportionate risk escalation and enable scrutiny of assurance.

9. Accountability and Responsibility: Individual Officers

9.1. **The Chair** is a Non-Executive Director who chairs the Board of Directors and the Council of Governors, ensuring the appropriate and proportionate scrutiny of the risk management arrangements within the Trust.

9.2. **Non-executive Directors (NEDs)** are responsible for providing an additional layer of scrutiny to seek assurance of the effectiveness of the Trust risk management and risk reporting systems. It is the responsibility of the NEDs through the Board level committee structure to assure that risks are appropriately reflected in the delivery of Trust strategic priorities and business objectives.

9.3. **Trust Governors** provide an additional layer of assurance that strategic decisions taken by the Board are informed by the views and opinions of local people, patients and staff.

9.4. The **Group Chief Executive** has overall accountability for risk management across the Trust and exercises this responsibility through membership of the Trust Board and attendance at the Audit Committee. The Chief Executive

delegates general risk management responsibilities to all executive directors. It is the Chief Executive who signs off the annual governance statement on behalf of the Board as the Accountable Officer with overall responsibility for risk management. They chair the Group Risk Oversight Committee.

9.5. **Group Executive Directors** are responsible for the identification, assessment and management of risk within their own area of responsibility as delegated by the Chief Executive. All Executive Directors oversee progress and provide position statements within the Board Assurance Framework for their areas of responsibility.

9.6. The **Group Director of Clinical Governance** is responsible for overseeing all elements of the implementation of the Risk Management Strategy across the Trust. They chair the Group Integrated Governance and Risk Committee.

9.7. The **Group Director of Corporate Governance/Board Secretary** is responsible for facilitating the population and update of the Board Assurance Framework

9.8. The **Group Head of Health and Safety** oversees the implementation of the Trust's Health and Safety Strategy and provide specialist health and safety management, advice and training in order to achieve high standards of health and safety management throughout the Trust in line with the Trust's Health and Safety policies.

9.9. The **Hospital Site, Managed Clinical Service and Local Care Organisation Chief Executives** are responsible for the implementation of this Strategy in their organisation. They are expected to participate in the strategic development of risk management in the Trust through representation on the Group Risk Oversight Committee. This ensures that the Trust's Strategy, policies, procedures, structure and decision making on risk management take into account the services provided by each Hospital site, Managed Clinical Service and Local Care Organisation. They are responsible for ensuring that their organisation has established, approved and assured Risk Management Governance Framework directly aligned to the Trust Risk Management Framework and Strategy to ensure a consistent approach to risk management throughout the organisation.

10. Accountability and Responsibility: Managers and staff

10.1. **Clinical, non-clinical and corporate service managers** are responsible for ensuring that risks in their area are identified, monitored and controlled according to the principles in this Strategy. The must allow time for risk issues to be included in governance meetings to support the effective identification, management and escalation of risk. Each service manager should identify a designated lead for Risk Management for their service.

10.2. The **Designated Lead** for risk management should ensure that staff are up to date with all risk management policies, documentation and understand their responsibility for conducting risk assessments, agreeing any action plans to reduce/mitigate risk and for incorporating such plans into the business planning process for their area. The designated lead should ensure that the training needs of the service have been assessed, adequate resource is available for the leadership role and the responsibilities of the leadership role are fulfilled and included within performance reviews.

10.3. **Department and ward managers** are responsible for ensuring that staff in the workplace understand risk management issues, adhere to risk management policies and procedures, receive and provide feedback regarding incidents and risks, and adopt changes to practice accordingly

10.4. **All Managers** have a direct responsibility for the health, safety and welfare of staff and for ensuring a safe environment for the delivery of care. Managers must apply the Trust's Health and Safety policies, and ensure that risks of this type are included within risk assessment, risk registers and action planning

10.5. **All staff**, including those on temporary or fixed term contracts, placements or secondments, and contractors, must keep themselves and others safe. They have a responsibility for managing incidents and risks within their area of responsibility. They must commit to being made aware of their responsibilities and of the risk management process through:

- induction into the Trust or into a new role
- discipline or department specific training
- management and supervisory training
- mandatory update training
- awareness raising or ad-hoc events
- Inclusion in personal development plans and Appraisal discussion

All staff should contribute to the identification of risk either as part of risk assessment or in reporting any risks, hazards, adverse events or complaints. All staff should then comply with any action requiring them to reduce risks which have been identified

11. Training

11.1. Contributing to risk management is the responsibility of all members of staff, and the Trust recognises the importance of providing risk education and awareness training for all clinical and non-clinical staff.

11.2. A formal risk management training needs analysis will be undertaken every three years to ensure that training provided meets the needs of specific groups of staff. The strategic risk management training needs analysis describes the key training requirements of all staff, including Board members. Progress against the Strategic Risk Management Training Needs Analysis is monitored through the Integrated Governance and Risk Committee, providing

assurance to the Group Risk Oversight Committee. Risk management training is part of the mandatory training for all staff. The Training Needs Analysis is included in the Risk Management Handbook.

11.3. The following training and education will be provided to support the implementation of effective governance and the risk management strategy itself.

11.4. The commitment and engagement of the **Board of Directors** within the organisation is paramount in creating the foundation for the implementation of this strategy and embedding the key principles throughout the Trust. To support this priority, relevant updates and awareness training programmes will be provided by both internal and external experts. For Executive and Non-Executive Directors, this will form part of the on-going Board development programme.

11.5. Risk management awareness and the identification and management of incidents is a structured part of the induction programme for **new staff**, including medical staff.

11.6. Risk management updates for **all staff** linked to specific clinical risk or health and safety training programmes, including raising awareness of key policies (for instance Health and Safety) will be provided through the Trust-wide and site level governance infrastructure.

11.7. Training for **line managers** in risk assessment and grading, high impact learning assessment processes following an incident, and the use of data and intelligence to support the identification of latent risk (for instance in variability in performance) will be provided, developed from the outcome of the training needs analysis.

12. Monitoring and assurance

12.1. Compliance with the Risk Management Strategy will be monitored through an annual report presented to the Group Risk Oversight Committee in May each year. The Annual report will confirm, as a minimum,

- The key individuals for risk management are discharging their responsibilities in line with the Strategy through attendance at key committees and there is evidence of activity through the minutes of those meetings
- The Board level Committees have discharged their responsibilities in line with their terms of reference in areas relating to risk management and escalation, including reporting arrangements into and between committees aligned to committee workplans and the Trust risk escalation framework
- The Board of Directors (through the work of the Group Risk Oversight Committee) and other Scrutiny and Operational Committees review the

organisation-wide risk register aligned to the Risk Escalation Framework as identified in the minutes of appropriate meetings
- Risks are assessed using a standard template and a Trust-wide grading matrix in line with the Risk Management Handbook
- Risk is managed locally through review of incident reporting, compliance with the Trust-wide clinical and non-clinical risk assessment process and evidence of maintenance of risk registers across the Trust, as evidenced through the work of the Integrated Governance and Risk Committee.

12.2. Where deficiencies are identified in the annual report, an action plan to address recommendations made will be assured through the Group Risk Oversight Committee.

13. Equality, Diversity and Human Rights Impact Assessment

13.1. The Trust Risk Management Strategy has been assessed by the author using the Trust's Equality, Diversity and Human Rights Impact Assessment

13.2. The Equality, Diversity and Human Rights Impact Assessment score is in the low priority category[1]

14. Consultation, approval and ratification process

14.1. The main local stakeholders are all represented in the Foundation Trust Governors, part of whose role is to ensure that the Trust operates in a way that is consistent with its statement of purpose. To ensure that all interested parties can keep themselves fully informed, this Risk Management Strategy is available on the Trust's website.

14.2. The key corporate stakeholders for this Framework and Strategy are:
- Hospital Sites/ Managed Clinical Services/Local Care Organisation
- Manchester Health and Care Commissioners
- Greater Manchester Health and Social Care
- Care Quality Commission
- NHS England/Improvement
- Health Education North West

14.3. The updates made to the Framework and Strategy do not impact the stakeholders apart from the Hospital Sites/MCS/LCO. A six-month programme of engagement was undertaken with Governance leads from each of the organisation to support the re-development of this Framework and Strategy.

[1] Equality Act 2010 http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

14.4. The Framework and Strategy was circulated for consultation to the members of the Integrated Governance and Risk Committee, Corporate Directors and the Executive Directors for review prior to submission to the Group Risk Oversight Committee for approval. When all comments were received, these were retained for governance purposes and amendments are made as deemed appropriate by the author

14.5. The Trust Risk Management Framework and Strategy will be ratified by the Board following approval at the Group Risk Oversight Committee. The ratification of the Risk Management Strategy must be documented in the Board minutes.

15. Dissemination and implementation

15.1. To effectively deliver this Risk Management Framework and Strategy there will be an action plan implemented which is designed to deliver:

- An articulated and demonstrated Board commitment to risk management
- A clearly articulated organisational risk appetite described and ratified on at least an annual basis by the Group Risk Oversight Committee on behalf of the Board of Directors
- Incorporation and integration of all risks from all sources into risk register development and oversight, aligned to the Principal risk structure
- Integration of processes and decisions about risk into future business and strategic plans
- An effective Trust Governance and Quality Framework to support the effective application of this strategy
- Integration of all sources of information, both reactive i.e. as a result of something that has happened (e.g. incidents) and proactive i.e. anticipating what could or might happen (e.g. risk assessments);
- Comprehensive systems of risk assessment to improve clarity and communication of risk, articulated in a risk management handbook
- Implementation of a consistent approach to risk management training
- Staff participation, consultation and accountability in risk management processes
- Effective systems to ensure that risks identified from organisational and service transformation are incorporated into operational risk assessments and mitigation strategies
- Effective mechanisms for incidents to be immediately reported and categorised by their potential impact, consequences and investigated to determine and learn from system failure or variability in an open and fair manner
- Formal and effective mechanisms to measure the effectiveness of risk management strategies, plans and processes, mapped against national and regulatory standards: an assurance framework and map.
- Preventative risk management principles and processes applied to the management of facilities amenities and equipment

- Risk management principles and processes applied to contract management especially when acquiring, expanding or outsourcing services
- Safe systems of work and practice in place for the protection and safety of patients, visitors and staff
- Plans for emergency preparedness, emergency response, business continuity and contingency
- Application of this strategy across the organisation, including hospital sites, Managed Clinical Services, the Local Care Organisation and corporately

15.2. The ratified Strategy will be available on the Trust Intranet under the Policies section and this will be communicated through various channels

15.3. The Strategy will be sent electronically to all key stakeholders.

15.4. Progress on implementation of this Strategy will be reported to the Group Risk Oversight Committee.

16. Appendices

Appendix 1: Risk Appetite Matrix
Appendix 2: Risk Management Governance Infrastructure

Appendix 1: Risk Appetite Matrix to support sensitive decision making[2]						
	0 Avoid	**1 Minimal**	**2 Cautious**	**3 Open**	**4 Seek**	**5 Mature**
	Avoid Avoidance of risk and uncertainty is a Key Organisational objective	ALARP (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as Value for M is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. Value for Money(VfM) is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ Regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation
Innovative/ Quality/ outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems/ technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

[2] Risk Appetite for NHS Organisations A matrix to support better risk sensitivity in decision taking www.goodgovernance.org.uk

Appendix 2: Governance Framework supporting risk management		
Level	**Structure**	**Function in relation to the Risk Management Strategy**
Holds to account	Council of Governors	The Council of Governors is responsible for holding the Non-Executive Directors to account for the performance of the Board of Directors on behalf of the Foundation Trust membership. In relation to risk management, they are presented with the Trust's annual accounts (including the Annual Governance Statement), any report of the auditor on them and the annual report at a general meeting of the council. The presentation of the annual report and accounts means that the Council can provide feedback to the board of directors based on its view of the overall performance of the board.
Accountable	Board of Directors	The Board of Directors has a clear focus on ensuring that the Trust operates to high ethical and compliance standards. In addition, it seeks to observe the principles set out in the NHS Improvement NHS Foundation Trust Code of Governance. The Board is responsible for the management of the Trust and for ensuring proper standards of corporate governance are maintained. The Board accounts for the performance of the Trust and consults on its future strategy through the Council of Governors. The Board of Directors receives exception reports against performance and quality standards and these assist the Board in scrutinising areas of high risk. The Board Assurance Framework is used to understand the impact of those areas of high risk on the achievement of the Trust's strategic objectives. The Board of Directors is responsible for • Monitoring progress against the Trust's Strategic Objectives • Identifying the significant risks that may threaten the delivery of the strategic objectives • Maintaining dynamic risk management arrangements including a well-founded risk register and Board Assurance Framework It is essential that the Board knows what key risks are and is satisfied that they are being properly managed.
Scrutiny (Trust-wide)	Audit Committee (Board Sub-Committee)	The Audit Committee reviews the establishment and maintenance of an effective system of audit, risk management and internal control across the whole of the organisation's activities (both clinical and non-clinical) that supports the achievement of the organisation's objectives. Of particular relevance the Committee reviews the adequacy of • The processes supporting all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the Care Quality Commission standards), together with any accompanying Head of Internal Audit statement, external audit opinion or any other appropriate independent assurance • The underlying assurance processes that indicate the degree of the achievement of strategic objectives, the effectiveness of the management of principal risks related to the appropriateness of the above disclosure statements • The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the counter fraud and security management service.
Scrutiny (Trust-wide)	Group Risk Oversight Committee (GROC) (Board Committee)	The GROC, chaired by the Group Chief Executive, attended by all Executive Directors and with senior representation from all sites/MCS/LCO, has oversight of all risks scoring 15 or more across the organisation on a bi-monthly basis, together with exception reports relating to new, escalating or updated risks scoring 15 or more. A detailed review of all risks scoring 15 or more is scheduled based on the immediacy of the risk or the complexity of the mitigation. In addition, other risks are considered by the Committee, escalated through the governance infrastructure, where because of interdependencies with other risks they are deemed to have a potential significant impact on the delivery of the Trust's Strategic Objectives. The GROC also considers risks escalated for review/support by Hospitals/MCS/LCO where further mitigation is outside of the control of the Hospital/MCS/MLCO (for example a national tariff issue). The GROC may also identify risks that require more detailed scrutiny arising from the Group Board Assurance Report, Group Board Assurance Framework, regulatory issues, national reports, patient/service user feedback and public interest issues The GROC considers risks in the principal risk infrastructure, supporting the management of the Board Assurance Framework, particularly in identifying gaps in assurance in relation to risk mitigation effectiveness. The work of the Committee also supports the compilation of the Annual Governance Statement.

Appendix 2: Governance Framework supporting risk management		
Level	**Structure**	**Function in relation to the Risk Management Strategy**
Scrutiny (Trust-wide)	Board Committees	The Board Sub-Committees, chaired by Non-Executive Directors, provide the Board of Directors with assurance that effective risk management and governance arrangements are in place in relation to their areas of work, Quality and Performance, Finance, Human Resources and Group Management. The Committees receive reports describing routine assurance in relation to the effectiveness of controls, and reports by exception where risks, gaps in assurance or negative assurance have been identified. The Board-Sub Committee monitor progress with the delivery of the Trust's strategic objectives and approve the related commentary and content within the Board Assurance Framework.
Responsible	Executive Director Chaired Committees	The Board Sub-Committees are supported by the work of Executive Director chaired Committees. These Committees, based on an established workplan, provide the Board Sub-Committees with assurance that effective governance associated with risk management is in place, including the effectiveness of risk escalation and assurance processes relating to areas of risk. A number of these Committees are part of a specific statutory framework, for instance Infection Prevention and Control, Information Governance and Health and Safety. These Committees receive assurance and escalation from a range of Committees and Groups
Responsible	Integrated Governance and Risk Committee	The Group Integrated Governance and Risk Committee is responsible for ensuring the delivery of the Risk Management Framework and Strategy and its integration with the Group Assurance Strategy. The Committee profiles risk across the organisation, ensuring risk interdependencies, learning and Trust-wide risks are being managed appropriately, using a range of reporting mechanisms and risk profiling techniques. The Committee also identifies areas of regulation and legislation where risks. These Committees receive assurance and escalation from a range of Committees and Groups, including the Site/MCS/LCO Risk Management Committees where risks to compliance with regulatory standards have been identified and uses the Trust's Assurance Framework, Map and Strategy to ensure actions taken in mitigation are effective and that there is appropriate escalation of risk. The IGRC reports into the GROC.
Accountable	Hospital/MCS/LCO Management Boards	The Hospital/MCS/LCO Management Boards are responsible for the management of the Hospital/MCS/LCO and for ensuring proper standards of corporate governance are maintained throughout the organisation. The Management Boards account for the performance of each individual organisation and receives exception reports against performance and quality standards and these assist in scrutinising areas of high risk**.** The work of the Management Boards is supported by a committee and governance infrastructure as defined in each Hospital/MCS/LCO's Governance Framework. The Management Boards are responsible for the escalation of risks scored at 15 or over or other risks that they believe may have an impact on the delivery of strategic objectives (for instance because they are cross cutting) to the GROC for scrutiny.
Responsible	Hospital/MCS/LCO Risk Management Committees	The Hospital/MCS/LCO Risk Management Committees are responsible for the overall oversight of risk exposure of the Hospital/MCS/LCO. They are responsible for effective escalation of risk to the Management Board, and providing a risk profile to the IGRC to support the identification of cross cutting risks and newly emergent threats. They are responsible for ensuring direct engagement with the IGRC to ensure that the integrated risk profile generated has good integrity and is used effectively to support risk oversight across the Trust.

Agenda Item 11.5

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Joint Group Medical Director
Paper prepared by:	Tanya Claridge, Acting Director of Clinical Governance
Date of paper:	July 2023
Subject:	Risk Appetite Statement: 2023 Update
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval • Ratify ✓
Consideration against the Trust's Vision & Values and Key Strategic Aims:	The Trust's Risk Management Framework and Strategy underpins the delivery of, and assurance processes related to the Trust's Vision, Values and Strategic Aims, fundamental to the implementation of the framework and strategy is the publication of a Board of Director's Risk Appetite Statement.
Recommendations:	The Board of Directors is asked to note the work undertaken through the Group Risk Oversight Committee to update the RMFS following its annual review and the outcome of an internal audit received in relation to the effectiveness of the controls in place The Board of Directors is asked to ratify the Trust's updated Risk Management Framework and Strategy 2022-2025
Contact:	Name: Dr Tanya Claridge, Acting Director of Clinical Governance Tel: 0161 276 5930

1. Introduction

The risk appetite statement (RAS) sets out how the Trust balances threats and opportunities in pursuit of achieving its strategic objectives. Understanding and setting a clear risk appetite level is essential to achieving an effective risk management framework. Establishing and articulating the risk appetite level helps to ensure that the Trust responds to risk consistently, in line with a shared vision for managing risk. There are risks the Trust is exposed to, such as legal compliance, where its risk appetite is very low. Conversely there are risks related to transformation of services or research and innovation where some risk taking is expected.

The RAS forms a key element of the Trust's assurance and governance framework. The Board of Directors recognises that, in pursuit of its strategic objectives, it may choose to accept different degrees of risk in different areas. Where the Board of Directors chooses to accept an increased level of risk it will do so, subject always to ensuring that:

- benefits and threats are fully understood before actions are authorised,
- it has sufficient risk capacity, with the effectiveness of existing controls fully understood
- proportionate measures to mitigate risk are established and monitored for effectiveness

2. Background

The Board of Directors ratified the Trust's Risk Management Framework and Strategy (2022/25) at its meeting in May 2022 (and will provided with an updated version of the Strategy and Framework at its meeting in July 2023, following the conclusion of the planned annual table-top review). The Risk Management Framework and Strategy describes a requirement for a Board of Directors Risk Appetite Statement (RAS):

'5.1. *The Trust understands risk appetite as a mechanism to translate risk metrics and methods into decisions, reporting and the day-to-day business of the Trust and that it provides a framework linking corporate strategy, target setting and risk management. Risk appetite is the amount of risk that any organisation is prepared to accept, or tolerate, or be exposed to at any point in time, and every risk needs to be assessed for the acceptable level of risk appetite.*

5.2.On an annual basis the Trust's Board of Directors, through the work of the Group Risk Oversight Committee, will confirm its risk appetite statement. The risk appetite statement will be generated from a formal discussion and will focus on the key categories of risk as described in (the Framework and Strategy) *and supported by the application of a Risk Appetite Matrix for NHS organisations* (See Appendix 1). *The Board's risk appetite, as detailed in the statement, will be aligned to the Trust's Strategic Objectives to support integration into the Board Assurance Framework (See Section 6)'*

3. Review process

A Board Development session was held in June 2023 to consider the

- implementation of the Risk Management Strategy and Framework,
- learning from the table-top review and the Internal Audit recommendations (following the significant assurance with minor opportunities for improvement opinion received in May 2023)
- refinement of the Principal Risk infrastructure supporting the Board Assurance Framework
- review and contextualisation of the risk appetite statement (RAS)

The deliberations at that workshop were used to draft a RAS, aligned as agreed to the Principal Risk infrastructure, which was subsequently reviewed by Executive and Non-Executive Directors. The proposed RAS and the associated background information is presented in section 3 of this paper.

4. **Proposed Risk Appetite Statement**

We have established, and continuously assess, the nature and extent of the principal risks that our organisation is exposed to, and is willing to take, to achieve our strategic aims - our risk appetite. We ensure that planning and decision-making reflect this assessment.

Our risk appetite is a balance that supports taking measured, assessed risk in the pursuit of certain strategic aims whilst managing and minimising risk in all operational functions. Acceptance of some calculated risk is often necessary to foster innovation and development.

We recognise that the challenging financial and operational environment that currently exists across the NHS inevitably means that, overall, there is a higher than ever inherent level of risk to the achievement of our strategic aims.

We are confident in setting our levels of risk appetite because we believe that our controls, forward scanning, and our systems designed to identify and respond to risk, are effective, and are supported by strong governance.

Our risk appetite statement is as follows:

We hold safety, quality of care, the experience of our patients and those who use our services, in the highest regard and we are measured in our approach, taking carefully considered risks that do not directly compromise the quality and safety of the care we provide.

We are prepared to accept the possibility of a short-term impact on operational performance outcomes where there is a potential for longer-term rewards, supporting innovation in the way we address our performance challenges, internally and with system partners. However, we will ensure that appropriate controls are in place to ensure that we maintain the essential standards of quality, safety, and patient experience.

We follow regulatory standards and are averse to compromising compliance with them. Should circumstances require it, we are prepared to tolerate the possibility of limited derogation from a regulatory standard on a temporary basis, having assessed the risk and put in place appropriate mitigation.

We are prepared to take limited risks with regards to the experience of our workforce. When attempting to innovate, we seek to understand where similar actions have been successful elsewhere before taking any decisions.

We are prepared to accept the possibility of some workforce risk, as a direct result from change and innovation, providing there is the potential for improved recruitment and retention, and developmental opportunities for our people.
We will invest in our infrastructure plans, within our financial resources, for the best possible return for our patients, our people and the organisation as a whole, recognising that the potential for substantial gain outweighs inherent risks.

We are prepared to accept some financial risk providing appropriate controls are in place. We have a holistic understanding of value for money which is demonstrated

through the contextualization of finance-related performance measures with other measures of performance in the Integrated Performance Report.

We will consistently work in partnership across the health and care system for the best possible return for our communities, with a significant appetite for challenging the status quo.

We seek to lead the way in terms of our research and innovation capability and capacity. We intend to use our optimised research and innovation capability and capacity to use it as a catalyst to drive positive change across our organisation.

We seek to lead the way and will prioritize new and innovative service delivery models, even in emerging fields. We will consistently and constructively challenge our current working practices, and those of system partners, to optimise our opportunities for transformation and service integration.

5. Recommendations

The Board of Directors is asked to note the process of review of the Trust Risk Appetite Statement and ratify the proposed Risk Appetite recommending its publication on the Trust's website.

Annex 1:

Risk Appetite for NHS Organisations
A matrix to support better risk sensitivity in decision taking

Developed in partnership with the board of Southwark Pathfinder CCG and Southwark BSU – January 2012

Good Governance Institute

Risk levels ▶ / Key elements ▼	0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective	1 **Minimal** (ALARP) (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.	3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM)	4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk).	5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Financial/VFM	Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern.	Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern.	Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments.	Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities.	Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'investment capital' type approach.	Consistently focussed on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself.
Compliance/ regulatory	Play safe, avoid anything which could be challenged, even unsuccessfully.	Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances.	Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge.	Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences.	Chances of losing any challenge are real and consequences would be significant. A win would be a great coup.	Consistently pushing back on regulatory burden. Front foot approach informs better regulation.
Innovation/ Quality/Outcomes	Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments.	Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations.	Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations.	Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery Responsibility for non-critical decisions may be devolved.	Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control.	Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice.
Reputation	No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern.	Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention.	Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest.	Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation.	Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation.	Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks.
APPETITE	**NONE**	**LOW**	**MODERATE**	**HIGH**	**SIGNIFICANT**	

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Agenda Item 11.6

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business and Trust Board Secretary
Date of paper:	July 2023
Subject:	Board Assurance Framework (June 2023)
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept ✓ • Assurance • Approval • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	A clear and effective Board Assurance Framework (BAF) enables the organisation to monitor the principal risks which are most likely to impact upon delivery of our Strategic Aims.
Recommendations:	The Board of Directors is asked to accept the latest BAF (June 2023) which is aligned to the MFT Strategic Aims.
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1. Background / Introduction

1.1 Significant risks to achieving the Trust's key strategic aims are reported to the Group Risk Oversight Committee (GROC) and through other established governance routes, dependent on the risk rating.

1.2 The Board Assurance Framework (BAF) presents the risks which have the most potential to impede MFT's delivery of its strategic aims. These risks are overseen by the relevant Board Scrutiny Committees.

1.3 MFT's new Risk Management Framework and Strategy (RMFS) was approved by MFT's Board of Directors in May 2022. It includes a Risk Appetite Statement and ten principal risks. To reflect the RMFS, a new format for the BAF was developed and presented for the first time to the Board of Directors in November 2022.

1.4 Since that Board meeting, the principal risks have been presented and reviewed at their relevant Scrutiny Committees and have been used to provide the context for discussions at those meetings.

1.5 At this meeting, the Board of Directors is receiving the annual review of the RMFS and, as part of this, is being asked to confirm the Risk Appetite Statement and Principal Risk Infrastructure for the following year.

1.5 This report presents the BAF for June 2023 (Appendix A). It incorporates the new Risk Appetite Statement and Principal Risk Infrastructure referred to above. It also responds to the recommendations from this year's review of the BAF by MFT's internal auditors.

2. Recommendations

2.1 The Board of Directors is asked to accept the latest BAF (June 2023) which is aligned to the MFT Strategic Aims.

EXECUTIVE SUMMARY

Strategic Aim	Principal Risk(s)	Executive lead (s)	Scrutiny Committee	Rationale for Assurance level	Current assurance level	Previous assurance levels	
						(last time presented to Board)	*(two Boards' ago)*
1. To focus relentlessly on improving access, safety, clinical quality and outcomes	1, 2, 3, 5, 6	Joint Group Medical Directors Group Chief Nurse Group Chief Operating Officer	Quality and Performance Scrutiny Committee	Operational perfomance continues is improving but needs to go further and faster to deliver on 2023/24 trajectories across all areas. Hospital/MCS/LCOs have clear improvement targets for the year ahead and there is variability currently in their delivery.Quality and safety initiaves are being implemented across the Trust. Lessons are being learned, and improvements in place, from the recent CQC warning notice for maternity services,			
2. To improve continuously the experience of patients, carers and their families	1, 2, 3, 6	Group Chief Nurse	Quality and Performance Scrutiny Committee	Systems and processes are in place to enable triangulation of all information / analysis through the various controls and enablers, surfaced through the governance systems and frameworks in place. There has been identification that not all risks related to essential standards of quality, safety and patient experience outcomes are fully controlled, however mitigation is in place with clear timeframes to address. Analysis of outcomes, triangulated with patient experience has identified that patients are waiting longer for their care/treatment than pre-pandemic, that there is inconsistency in achieving reduction in attributable healthcare associated infections and mealtime processes. All data is analysed and triangulated to learn lessons and drive improvements within services. The clinical accreditation programme is incentivising and delivering service improvement. MyMFT has provided an additonal and popular route for patients to engage with MFT.			
3. To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best	4	Group Executive Director of Workforce & Corporate Business	Workforce Scrutiny Committee	Staff survey imrovement plans and a creative listening well plan are being implemented.The Employee health and wellbeing programme is proving popular with tangible results. The Freedom to Speak Up programme is now embedded across the Trust. The reduction in absence rates and agency use will need to be sustained to meet annual plan targets.			
4. To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce fit for the future	5	Group Executive Director of Workforce & Corporate Business	Workforce Scrutiny Committee	MFT's People Plan continues to be successfully implemented alongside the Diversity Matters Strategy. Non-medical appraisal rates and level 2/3 mandatory training compliance levels are lower than required. MFT's apprenticeship scheme continues to be successful. A digital maturity programme has been initiated to develop workforce skills.			
5. To use our scale and scope to develop excellent integrated services and leading specialist services	6, 10	Group Director of Strategy	Board of Directors	Development of specialsied services (e.g. lung health checks, ATMPs, rare conditions, genomics, Sickle Celll Disease) through clinical service strategies, single services (e.g. cardiac, general surgery, head & neck, gastroenterology, vascular, breast, urology, orthopaedics, infectious diseases) and integrated community and social care services through the LCOs continues. Disaggregation of NMGH services is ongoing with plans to deliver the safe transfer of responsibilities within the available capacity and resource under continual review.			
6. To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the populations we serve	9	Joint Group Medical Directors	Board of Directors	R & I continues to thrive at MFT. MFT is the highest recruiter to research studies in GM, and 4th highest nationally. The Manchester BRC and CRF were launched in Marhc 2023 and MFT will now host the North West RRDN. The outputs from R & IU activity continue to lead to ground-breaking treatment for our patients.			
7. To achieve and maintain financial sustainability	7	Group Chief Finance Officer	Fiannce and Digital Scrutiny Committee	At the end of Month 2, MFT's deficit positon is £4.8m worse than planned. We require delivery of a challenging Waste Reduction Programme for 2023/24 and current forecasts show a shortfall in delivery although the WRP has achieved slightly above the trajectory.			
8. To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda	6,8	Joint Group Medical Directors Group Chief Operating Officer Group Director of Strategy	Board of Directors	MFT has an active role within the Greater Manchester Inetgrated Care System contirbuting to all relevant workstreams. MFT's Green Plan continues to be successfully implemented. Our Health Inequalities Group oversees a number of workstreams to reduce health inequalities in the local population. Recruitment initiatives to encourage local applicants are in place.			

Principal risks	
1. Failure to maintain essential standards of quality, safety, and patient experience	6. Failure to implement and embed infrastructure plans including digital and estates
2. Failure to improve operational performance	7. Failure to embed the Trust's approach to value and financial sustainability
3. Failure to meet regulatory expectations, and comply with laws, regulations, and standards	8. Failure to work with system partners to address health inequalities, and deliver social value and sustainability
4. Failure to effectively address issues affecting staff experience	9. Failure to expand MFT's research and innovation capability and capacity
5. Failure to effectively plan for, recruit, and retain a diverse workforce with the right skills	10. Failure to deliver the required transformation and integration of services

Principal risk 1: Failure to maintain essential standards of quality, safety, and patient experience

Lead Executive Director (s): Group Chief Nurse / Joint Group Medical Directors
Scrutiny Committee: Quality and Performance Scrutiny Committee
Assurance Committee: Quality and Safety Committee

Strategic aims under threat

1. To focus relentlessly on improving access, safety, clinical quality, and outcomes
2. To improve continuously the experience of patients, carers, and their families

Risk appetite

We hold safety, quality of care, the experience of our patients and those who use our services, in the highest regard and we are measured in our approach, taking carefully considered risks that do not directly compromise the quality and safety of the care we provide.

Principal Risk rating				
Initial	Current	Residual	Target	Progress
20	15	15	10	

Controls / Enablers

Frameworks / Strategies / Plans
Risk Management Strategy and Framework
Safety Oversight System
Patient safety insight, response and learning Policy
Patient Safety Incident Response Framework
Infection Prevention and Control Standards, Policies & Procedures
Access Policy
EPRR policy
Health and Safety Policies
Assurance Framework and Map
Quality and Safety Strategy
Annual Plan
Infection Prevention & Control Board Assurance Framework
Dementia Strategy
Adults / Children's and Young People End of Life and Palliative Care Strategy(s)
Wound Care Strategy
MyMFT application

Committees / Groups
Group Quality and Safety Committee
Group Infection Control Committee
Clinical Practice Oversight Committee
Group Nutrition & Hydration Committee
Complaints Review Group

Teams / Services / Functions / Programmes
Clinical Accreditation Programme
What Matters to Me Programme
Veterans Programme
Gloves Off Campaign
Falls Collaborative
Bee Brilliant Programme (Call To Action)
Resilient Discharge Programme
Chaplaincy Services
Child and Adolescent Mental Health Service
Quality Impact Assessment and Equality Impact Assessments (relating to service change or waste reduction programmes)

Profiles
Patient Safety Profile and Plan
Safety Critical Policy Profile
Regulator relevant policy Profile

Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Implementation of external recommendations	Implementation of revised policy, governance and assurance framework	30/6/2023	On track
Safety Critical Policies-governance and review sub-optimal	Action plan to address in place (monitored by IGRC)	30/9/2222	Compromised
Availability and use of system reliability measures to identify potential risk-aligned to informatics capacity risk	Risk assessment with clear action plan to undertaken-interim patient safety profiles for areas of high risk in place	31/5/2023	On track
Mental Health Strategy not yet in place	The Trust's Mental Health Strategy has been in development since November 2022. Extensive consultation with key stakeholders (GMP, GMMH, Pennine Care, CAMHS / ICB) completed in May 2023. Strategy will be ratified in August 2023.	31/08/2023	On track
CQC inspection Maternity-significant improvement required (safe domain)	Executive led action plan in place to address requirements	23/6/23	New
Carers Strategy in development	Final Stakeholder exercise due for completion in July 2023. Strategy to be ratified in September 2023	30/09/23	New
Attributable Healthcare Acquired Infections above thresholds (in some alert organisms)	IPC Strategy to be refreshed with focus on specific learning from root cause analysis of incidences.	31/10/2023	New

Sources of Assurance (negative/positive/inconclusive)

Site/MCS/LCO assurance		Group assurance		External Assurance	
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report
Minutes of Site/ MCS /LCO Quality and Safety Committees, Accountability Oversight Framework Escalation of risks to quality and Safety Committee from site/MCS/LCO governance, Safe Staffing Reports	End Year Reviews: Infection Prevention & Control/Safeguarding PLACE Audit results	Quality report Integrated Risk Profile Quarterly/Annual reports: complaints, patient experience, accreditation Reports to QPSC Reports to Q & S committee	Hospital/MCS/LCO reviews Quality Account QPSC (16/6): SMH presentation to extraordinary QPSC (20/6): IPR (May data); PSIRF implementation update. Series of Deep Dives: Urgent/Emergency Care; Elective Care; Cancer Services; Diagnostics Report on learning from Never Events; Ockenden IEA4 report; SMH learning from serious incidents report Audit Committee (20/6): Annual report 2022/23 QIA and EQIAs via WAVE programme	Internal audit, accreditation, peer review, regulatory inspection	Falls internal audit Local Maternity & Neonatal Service Report following Visit to Triage across All Sites Healthwatch Report: Enter and View at NMGH (Wheelchair Access)

Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Provision of meals (meal times processes) standards inconsistently achieved (as noted in Clinical Accreditation / PLACE audits and Qhat Matters to Me Survey results).	Task and Finish Group in place, led by the Improving Quality Team, developing focussed actions. The task and finish group will report to the Nutrition and Hydration Committee.	30/09/203	New
Internal Audit: Falls Prevention, Assessment and Management Processes. Partial assurance with improvements required.	Action plan in place-focused on Training, development of Power BI reporting, care planning, outcomes, and actions from monthly audits.	31/12/203	New
CQC inspection Maternity-effectiveness of Board reporting and escalation	Executive led action plan in place to address requirements due to CQC on 23rd June 2023	23/6/2023	Completed
Internal Audit-Learning from harm-significant assurance	Policy review aligned to PSIRF implementation	31/5/23	New
NICE Guidance implementation assurance process uncertain	Revised assurance process to be implemented	30/6/23	On track
Real time quality assured quality and safety data	Implementation of HIVE and development of dashboards	30/09/23	On track
Understanding of the impact of inequality on the safety of patients	Programme of work in place to address optimising insight		On track
Inconsistent roll out of IQP programmes (noted through Clinical Accreditation)	Ensure embedded in all areas		On track

Principal risk 2: Failure to improve operational performance

Strategic aims under threat

Lead Executive Director (s): Group Chief Operating Officer
Scrutiny Committee: Quality and Performance Scrutiny Committee
Assurance Committee: Operational Excellence Board

1. To focus relentlessly on improving access, safety, clinical quality, and outcomes
2. To improve continuously the experience of patients, carers, and their families

Risk appetite	Principal Risk rating				
	Initial	Current	Residual	Target	Progress
We are prepared to accept the possibility of a short-term impact on operational performance outcomes where there is a potential for longer-term rewards, supporting innovation in the way we address our performance challenges, internally and with system partners. However, we will ensure that appropriate controls are in place to ensure that we maintain the essential standards of quality, safety and patient experience.	20	15	15	10	

Controls / Enablers		Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
MFT recovery programme (including response and recovery group) Trust Access Policy Performance management frameworks Performance Governance infrastructure Clinical Policies/Guidance Elective PMO hub Enhancement of Trafford Elective Hub Health and Safety Related Policies Health inequalities programme Data Quality Governance infrastructure Group Recovery Board Accountability Oversight Framework Operational Excellence Board	Deep dives EPRR governance framework Quality and Safety Strategy Strategic Oversight Framework People plan Risk management framework and strategy Training programme in place for key Operational and Clinical Systems Digital strategy Peer reviews for cancer Performance dashboards Annual Plan Robust on-call arrangements Hive stabilisation Board Robust oversight of performance returns to external bodies	Stabilisation of the administration pathways/build following launch of Hive EPR	Workplan in place following Root and Branch Review	Dec 23	On track
		Interpretation and understanding of key components of HIVE data sets	Domain Group for each performance dashboard development with explanation and user guides for Cancer, diagnostics, admin and clerical, RTT and all patient flow	March 24	On track
		Systems working together to have visibility of data for signing off prior to being submitted externally	Scoping exercise to identify and understand data being submitted automatically versus control sign off.	Sept 23	On track
		Urgent Care Delivery Plans in place but not linked to an overarching Strategy	Strategy in development	Sept 23	On track
		Discharge policy refresh	Policy in development	Oct 23	On track

Sources of Assurance (negative/positive/inconclusive)						Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance		Group assurance		External Assurance					
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report				
Capacity and delivery plans Risk profiles Performance committee minutes Risk management committee minutes Accountability Oversight Framework Trajectories Hospital/MCS Management Board minutes		Weekly response and recovery group Routine Committee reports Integrated Group Risk Profile Accountability Oversight Framework Integrated Performance Report Group Recovery Board reports Operational Excellence Board reports Improvement Workstreams actions plans and progress reports	Hospital/MCS/LCO reviews QPSC (20/6): IPR (May data); elective priorities checklist Audit Committee (20/6): Annual report 2022/23	Internal Audit Peer review GIRFT Tier 1 calls – long waits, urgent care Carnell Farrar Review of Elective recovery plans	ICS performance review	Ability to align delivery plans to performance through the AOF	Review and refresh of AOF Framework	Oct 23	On track
						Required single set of metrics measured through the AOF, IPR and BAR aligned to Hospital plans	Review and refresh of AOF metrics	Oct 23	On track

Strategic aims under threat

Principal risk 3: Failure to meet regulatory expectations, and comply with laws, regulations and standards

Lead Executive Director (s): Joint Group Medical Directors, Group Chief Nurse
Scrutiny Committee: Quality and Performance Scrutiny Committee
Assurance Committee: Quality and Safety Committee

1. To focus relentlessly on improving access, safety, clinical quality and outcomes
2. To improve continuously the experience of patients, carers and their families

Risk appetite

We follow regulatory standards and are averse to compromising compliance with them. Should circumstances require it, we are prepared to tolerate the possibility of limited derogation from a regulatory standard on a temporary basis, having assessed the risk and put in place appropriate mitigation.

Principal Risk rating

Initial	Current	Residual	Target	Progress
20	15	15	10	

Controls / Enablers

Frameworks / Strategies / Plans
Risk management strategy and framework
Policy and procedure infrastructure covering all legislation
Assurance Framework and map
External visits register
Estates and Facilities Policies and Site Plans

Committees / Groups
Health & Safety Committee
Quality & Performance Scrutiny Committee

Teams / Services / Functions / Programmes
Site and group based specialist teams responsible for regulated activity (e.g. fire safety, asbestos management, medical gases)
Nominated individuals in place across the Trust as required by legislation
Child and Adolescent Mental Health Service
External Authorising Engineer/Independent Adviser Audit Programme

Profiles
Patient Safety Profile and Plan
Safety Critical Policy Profile
Regulator relevant policy Profile

Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Policy and guideline accessibility	Requires improved electronic management system-procurement supporting potential tender process	31/7/2023	On track
Assurance Framework and Map. limited engagement with Sites/MCS/LCO	Additional resource identified to support site/MCS/LCO implementation	30/5/2023	On track
CQC Maternity inspection-controls supporting Board and scrutiny committee sub-optimal (including data)	Review of assurance reporting and escalation to Board and Scrutiny Committees	30/5/2023	Completed
Consent policy	Requires review in light of EPR implementation-policy out for final consultation		On track
Policy and guideline accessibility	Requires improved electronic management system-procurement supporting potential tender process	31/7/23	On track
CQC inspection Maternity-effectiveness of Board reporting and escalation	Executive led action plan in place to address requirements due to CQC on 23rd June 2023	23/6/2023	Completed
Out of date asbestos surveys and survey information for 3 acute sites not currently held in one system.	Asbestos surveys are currently being undertaken across the acute hospital sites with survey information to be inputted directly onto the MFT asbestos register (Concerto)	30/11/23	On track
Strengthening of fire safety work risk assessment required	Risk assessment underway and controls and actions being identified and agreed	31/7/23	On track

Sources of Assurance (negative/positive/inconclusive)

Site/MCS/LCO assurance		Group assurance		External Assurance	
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report
Quality and risk governance infrastructure-Committee meetings and risk escalation Health and Safety Compliance Auditing		Annual reporting schedule External visits register reporting Annual Governance Statement Annual Health and Safety report Annual Safeguarding report Annual Infection Prevention & Control Report Infection Prevention & Control Board Assurance Framework Data Security Protection toolkit High Priority Clinical Audit Programme Clinical Audit Annual report Assurance framework and map Annual HTA report	Audit Committee (20/6): Annual report 2022/23	Regulator visits and inspections External audit opinion of Annual Governance Statement QSP self-declaration Annual Data Security Protection Toolkit submission Internal audit programme	CQC Warning Notice section 29a maternity services (previously reived)

Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Application of Duty of Candour: timeliness and quality	Review completed-improvement plan to be developed and implemented	31/3/23	Complete-reporting to Patient Safety Committee in May 23
Mental Health Strategy not yet in place	The Trust's Mental Health Strategy has been in development since November 2022. Extensive consultation with key stakeholders (GMP, GMMH, Pennine Care, CAMHS / ICB) completed in May 2023. Strategy will be ratified in August 2023.	31/08/2023	On track
Effectiveness of application of the MCA (internally)	Audit of compliance	31/08/2023	On track-outcome awaited

Strategic aims under threat

Principal risk 4: Failure to effectively address issues affecting staff experience

Lead Executive Director: Group Executive Director of Workforce & Corporate Business
Scrutiny Committee: Workforce Scrutiny Committee
Assurance Committee: Workforce and Education Committee

3. To make MFT a great place to work, where we value and listen to our staff so that we attract and retain the best

Risk appetite

We are prepared to take limited risks with regards to the experience of our workforce. When attempting to innovate, we seek to understand where similar actions have been successful elsewhere before taking any decisions.

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Principal Risk rating

Initial	Current	Residual	Target	Progress
20	12	8	4	

Controls / Enablers

NMAHP Safe Staffing Escalation Policy and risk framework Safer Nursing Care Tool (SNCT) census Workforce-related KPIs Workforce governance, policies and procedures Accountability Oversight Framework Medical Directors Workforce Board NMAHP Professional Board Staff engagement / networks Staff side liaison Guardian of Safe Working H & S risk assessments Workforce and Education Committee Employee Relations Oversight Group	MFT People Plan Informatics Strategy Diversity Matters Freedom to Speak up programme EHW programme Leadership and Culture Strategy NMAHP International recruitment Wellbeing Guardians Mental Health First Aiders Workforce Strategic Equalities Committee Designated Non-Executive Director – Wellbeing. Executive Director lead for Freedom to Speak up

Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Enhanced Employee Health and Wellbeing Strategy required	Strategy being refreshed	30/6/23	On track
People plan deliverables not fully implemented	Full implementation	March 2024	On track
New National Long Term Workforce Plan about to be published (Summer 2023)	Review MFT People Plan in alignment with National publication	September 2023	On track
Review of leadership and culture approach ongoing as part of the Group Chief Executive Engagement Plan.	Senior Leadership engagement workshop planned to develop strategy	September 2023	On track

Sources of Assurance (negative/positive/inconclusive)

Site/MCS/LCO assurance		Group assurance		External Assurance	
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report
Workforce dashboards Daily safe staffing huddles (nursing and midwifery) Safe staffing risk escalation process Job plan status reports Roster confirm and challenge Staff appraisal records Personal objective setting		Accountability Oversight Framework Bi-annual Safer Staffing reports Safer Nursing Care Tool 7DS joint assurance group and action plan GoSW reports FTSU reports Integrated risk profile Workforce Race Equality Standard Workforce Disability Equality Standard Annual NMC Revalidation report Regulatory assurance framework and map Minutes of relevant Group Committees	HRSC 20/6: IPR (May data); GoSW report; Annual FTSU report; Staff survey Improvement action; Diversity Matters update; People plan update; Workforce Digital Strategy update; EHW update Audit Committee (20/6): Annual report 2022/23	National Staff Survey and associated pulse surveys. WRES Report WDES Report Gender Pay Gap Report. NHS E ED&I Improvement Plan	

Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Allocate Medical Workforce solution	Roll out to be completed	31/3/24	On track
Formal response to NHS E ED& I Improvement Plan high impact actions –	Plan in preparation.	30th July 2023	On track

Strategic aims under threat

Principal risk 5: Failure to effectively plan for, recruit, and retain a diverse workforce with the right skills

Lead Executive Director: Group Executive Director of Workforce & Corporate Business
Scrutiny Committee: Workforce Scrutiny Committee
Assurance Committee: Workforce and Education Committee

4. To implement our People Plan, supporting our staff to be the best that they can be, developing their skills and building a workforce for the future

Risk appetite	Principal Risk rating				
	Initial	Current	Residual	Target	Progress
We are prepared to accept the possibility of some workforce risk, as a direct result from change and innovation, providing there is the potential for improved recruitment and retention, and developmental opportunities for our people.	20	16	8	4	

Controls / Enablers		Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Talent Management Programme Workforce predictive modelling Mentorship and coaching Top Leaders' Programme Staff Appraisal Workforce plans Workforce governance structures EDI policies Recruitment policies Attraction Strategy Newly Appointed Consultants Programme.	MFT People Plan Diversity Matters Leadership and Culture strategy NMAHP international recruitment Talent Board Removing Barriers Programme. Communications Strategy. Talent Management. Widening Participation Strategy Veterans and Reservists Plan Apprenticeship Strategy.	People plan deliverable not fully implemented	Full implementation	March 2024	On track
		New National long term Workforce plan about to be published (Summer 2023)	Review MFT People Plan in alignment with National publication	September 2023	On track
		New publication of ED&I High Impact actions	Review and develop local plan	July 2023	On track
		Review of leadership and culture approach ongoing	Senior Leadership engagement workshop planned to develop strategy	September 2023	On track
		Workforce planning is short term of annual nature	Development of a medium to long term strategic workforce plan	September 2023	On track

Sources of Assurance (negative/positive/inconclusive)						Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance		Group assurance		External Assurance					
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report				
Workforce dashboards Staff appraisal records		Accountability Oversight Framework Minutes of relevant Group Committees Integrated Performance Report	QPSC 20/6: IPR (May data), GoSW report; Staff survey Improvement action; Diversity Matters update; EHW update Audit Committee (20/6): Annual report 2022/23 Workforce and Education Committee 23/6	National Staff Survey and associated pulse surveys. WRES Report WDES Report Gender Pay Gap Report. NHS E ED&I Improvement Plan. Internal Audit Report.		Integrated Performance Report metrics require refresh	Alignment Workforce metrics integrated within the Dashboard	July 2023	On track

Principal risk 6: Failure to implement and embed infrastructure plans including digital and estates

Lead Executive Director: Group Chief Finance Officer, Group Deputy Chief Executive, Group COO
Scrutiny Committee: EPR Scrutiny Committee, Finance and Digital Scrutiny Committee
Assurance Committees: Strategic Capital Group, EPR Programme Board

Strategic aims under threat

1. To focus relentlessly on improving access, safety, clinical quality and outcomes

2. To improve continuously the experience of patients, carers and their families

5. To use our scale and scope to develop excellent integrated services

Risk appetite

We will invest in our infrastructure plans, within our financial resources, for the best possible return for our patients, our people and the organisation as a whole, recognising that the potential for substantial gain outweighs inherent risks.

Principal Risk rating				
Initial	Current	Residual	Target	Progress
20	15	12	10	

Controls / Enablers		Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Annual Plan: - Capital plan within GM envelope to support investment in infrastructure - Revenue plan supporting ongoing costs of infrastructure Digital strategy approved by Board of Directors 2022 Finance and Digital Scrutiny Committee EPR Scrutiny Committee EPR Programme Board Group Informatics Strategy Board Strategic Capital Group NMGH redevelopment programme Hive Stabilisation Governance – Pathway Councils, Pathway Council Oversight Committee, Delivery Authorities & Medical Directors Forum 'Sprints' to address Hive issues Digital maturity programme Project RED	Informatics workplan delivering detail of Digital strategy Gartner support to senior Informatics staff to ensure external developments are understood and adopted where relevant What good looks like (WGLL) Digital Nursing Implementation of Digital NMAHP team	Capacity of Informatics team – ability to recruit appropriately skilled staff	Use of contractors to deliver specific project work	Ongoing	On track
		23/24 Capital Plan is yet to be finalised at GM System level.	Review in progress of 23/24 proposed schemes against E&F risk register assessments to ascertain allocation of funding on a risk based approach if funding allocation is significantly reduced.	31/07/23	On track
		NHS funding allocation 'range' provided for the New Hospital Programme (NHP) Current 'funding envelope' for NMGH NHP represents a 25% reduction in capital envelope compared to the current Preferred Way Forward.	Ongoing discussions between Director of Strategic Projects E&F and New Hospital Programme Team. Final business case to be developed.	31/3/24	On track
		Asset management and Planned Preventative Maintenance (PPM) tasks recorded on different systems at NMGH	Review of PPMs and consolidation onto Concerto system in progress	31/10/23	On track

Sources of Assurance (negative/positive/inconclusive)						Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance		Group assurance		External Assurance					
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report				
Operational Readiness Authority Pathway Councils Hospital/MCS Post Live Readiness Assessments, including post live metrics Reports to North Manchester Redevelopment Oversight Group Delivery authorities		Reports to FDSC Reports to GISB, SCG Reports to EPR Scrutiny Committee	Confirmation of cohort 3 funding for NMGH development Audit Committee (20/6): Annual report 2022/23 FDSC (27/6): Group CIO report What good looks like assurance to NMAHP professional board	Deloitte Hive Gateway reviews Internal audit	Hive Gateway 5 Report	Weaknesses in assurance identified through internal audit.	Assurance weakness identified through audit with associated actions are logged and a defined programme is established, monitored and reviewed	Ongoing	In progress

Strategic aims under threat

Principal risk 7: Failure to embed the Trust's approach to value and financial sustainability

Lead Executive Director: Group Chief Finance Officer
Scrutiny Committee: Finance and Digital Scrutiny Committee
Assurance Committee:

7. To achieve and maintain financial sustainability

Risk appetite	Principal Risk rating				
	Initial	Current	Residual	Target	Progress
We are prepared to accept some financial risk providing appropriate controls are in place. We have a holistic understanding of value for money which is demonstrated through the contextualization of finance-related performance measures with other measures of performance in the Integrated Performance Report.	25	20	15	15	

Controls / Enablers		Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Finance and Digital Scrutiny Committee Audit Committee Annual Plan: – set to include risks and the Waste Reduction Programme challenge - Hospital/MCS/LCO/Corporate control level financial targets including WRP targets SFIs/Standing Orders and Scheme of Delegation Trust electronic financial system reflects the approved SFIs and Scheme of Delegation Financial Control policy infrastructure Finance governance infrastructure is replicated in all operating units with a qualified Finance Director as part of each operating units Senior Leadership Team. Finance Accountability Framework as subset of Accountability oversight framework Monthly/Bimonthly finance reviews take place of Hospital financial performance Business Case sign-off process	Operational Excellence Board Group Recovery Board GM and regional meetings Quality Impact Assessments & Equality Impact Assessments undertaken on WRP schemes Management of Temporary staffing 2 year financial recovery plan is in development, including tightening of internal controls on expenditure QIA & EQIA on WRP Management of temporary staffing	Weaknesses in controls identified through external audit, internal audit and counter fraud. Gaps caused by overall system pressure are emerging. Pressures on Control Totals resulting from workforce shortages, leading to greater use of higher cost Bank and agency, insourcing arrangements, collective action such as BMA rate card and refusal to offer ECLs, allied to activity pressure to deliver 65 week wait targets mean that Hospital Control Totals and WRP savings are not achieved or only achieved non recurrently and thus MFT fails to achieve its control total. Pressure on Group control total arising from GM ICB deficit position for 23/24 and apportionment methodology for system savings.	Control weakness with associated actions are logged and a defined programme is established, monitored and reviewed New pressures emerging have seen tightening of expenditure controls, now extended to all frontline services and supporting services but remain subject to QIA. Ongoing work to support hospitals and corporate in achievement of targets by new control totals for 23/24 and enhanced review through regular Finance and Productivity meetings, early intervention if "off plan". Established Group Recovery Board under the Group CEO and extended support to WRP process with additional resources and senior input Ongoing discussions with ICB and partners to identify genuine system-wide savings	March 2024	Work in progress

Sources of Assurance (negative/positive/inconclusive)						Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance		Group assurance		External Assurance					
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report				
The SLT of each unit receives a finance report providing a summary of all financial performance metrics at regular meetings The SLT receives a report on progress to achieve WRP/Cost Improvement Programmes across the operating unit The CEO of each unit signs off and supplies to Group a monthly result and forecast pack. SLT attend finance reviews and AOF meetings	Month 2 forecasts	Finance reporting to Audit Committee, GMB, FDSC and BoD Annual accounts GMB finance reports Group Risk Committee receives a report on high-level financial risks Workplans Group Recovery Board Integrated Performance Report	Audit Committee (20/6): Annual report 2022/23; Annual Accounts (2022/23) FDSC (27/6): Group CFO report; WRP update; National Cost Collection report	Monthly reporting to ICB Monthly NHSE reporting Head of Internal Audit opinion External Audit reviews, Value for Money conclusion and external audit/going concern opinion Internal Audit Assessment of controls Counter Fraud Service Assessment Reviews by HMRC Additional external review commissioned to ensure all WRP opportunities have been identified.	Head of Internal Audit Opinion External Audit – Audit Completion Report, value for money conclusion and going concern opinion	Weaknesses in assurance identified through external audit, internal audit and counter fraud. Gaps caused by system pressure are emerging	Assurance weakness with associated actions are logged and a defined programme is established, monitored and reviewed	Ongoing	In progress

Strategic aims under threat

Principal risk 8: Failure to work with system partners to address health inequalities, and deliver social value and sustainability

Lead Executive Director (s): Joint Group Medical Directors, Group COO, Group Director of Strategy
Scrutiny Committee: Board of Directors
Assurance Committee: Health Inequalities Group

8. **To work with partners and play our part in addressing inequalities, creating social value and advancing the wider green agenda**

Risk appetite	Principal Risk rating				
	Initial	Current	Residual	Target	Progress
We will consistently work in partnership across the health and care system for the best possible return for our communities, with a significant appetite for challenging the status quo.	16	12	12	8	

Controls / Enablers		Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Health Inequalities Board MFT Health Inequalities Strategy MFT Recruitment Strategy EDI strategy MFT inequalities dashboard Climate Strategy Board NMGH redevelopment programme Widening Participation team Diversity Matters MFT Green plan GM ICB strategy MFT reps in key roles in ICS for example GM Antimicrobial Group Senior leadership in subgroups of PFB Senior partners in adult and children's safeguarding	Manchester and Trafford Health and Wellbeing Boards	Trafford Health and Wellbeing Board approval of health inequalities strategy	Scheduled for approval at next meeting	July 2023	On track
		Health inequalities dashboard yet to be finalised	Dashboard to be finalised	July 2023	On track
		Public health consultant not yet in post	Recruitment process complete, starting date agreed	September 2023	On track

Sources of Assurance (negative/positive/inconclusive)						Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance		Group assurance		External Assurance					
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report				
Hospital/MCS/LCO reports to Health Inequalities Board		Sustainability report in Annual Report Board progress report on Green Plan QPSC reports on health inequalities WSC EDI reports NMGH updates to Board Accountability Oversight Framework Health inequalities reports to Trust Board	Confirmation of cohort 3 funding for NMGH development Audit Committee (20/6): Annual report 2022/23	Minutes of Health and Wellbeing Board Minutes of GM ICB and ICP Minutes of locality Boards		Health inequalities dashboard yet to be reported through Trust governance	Finalise dashboard and begin regular reporting	July 2023	On track

Strategic aims under threat

Principal risk 9: Failure to expand MFT's research and innovation capacity and capability

Lead Executive Director: Joint Group Medical Director
Scrutiny Committee: Board of Directors
Assurance Committee: Research Governance Committee

6. To develop our research and innovation activities to deliver cutting edge care that reflects the needs of the population we serve

Risk appetite	Principal Risk rating				
	Initial	Current	Residual	Target	Progress
We seek to lead the way in terms of our research and innovation capability and capacity. We intend to use our optimised research and innovation capability and capacity to use it as a catalyst to drive positive change across our organisation.	10	10	6	4	

Controls / Enablers		Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Research governance committee MAHSC GM NIHR oversight board BRC board CRN board CRF board LCRN board	Timely recruitment to deliver SMART objectives for NIHR infrastructure Work with NIHR to develop capacity, workforce and EDI/PPIE strategy. Agree principals for commercial engagement with NIHR to optimise budgets and deliver SMART objectives Hospital/MCS/LCO engagement with R & I	None at present			

Sources of Assurance (negative/positive/inconclusive)						Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance		Group assurance		External Assurance					
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report	None at present			
		R & I annual report to Board Reports to BRC board Reports to CRF board Reports to LCRN board Reports to GM oversight board	Audit Committee (20/6): Annual report 2022/23	Peer review from NIHR					

Principal risk 10: Failure to deliver the required transformation and integration of services

Lead Executive Director: Group Executive Director of Strategy
Scrutiny Committee: Board of Directors
Assurance Committee: Group Service Strategy Committee (EPR Programme Board oversees Hive contribution to service transformation)

Strategic aims under threat

5. To use our scale and scope to develop excellent integrated services and leading specialist services

Risk appetite

We seek to lead the way and will prioritize new and innovative service delivery models, even in emerging fields. We will consistently and constructively challenge our current working practices, and those of system partners, to optimise our opportunities for transformation and service integration.

Principal Risk rating				
Initial	Current	Residual	Target	Progress
12	9	9	6	

Controls / Enablers		Gaps/weaknesses in controls/enablers	Action being taken to address gaps/weaknesses	Target date	Progress
Transformation programme structures at System and Trust level including Programme Board and workstream groups Annual Plan MFT Clinical Services Strategy MFT Single Service Board Single Service Boards Group Service Strategy Committee (GSSC) Single Service Development Assurance Process Manchester Clinical Academic Centre Key partners influencing major service delivery/transformation eg Cancer/End of Life/Infection prevention and control/Workforce Provider Federation Board GM Executive Groups GM Elective Recovery Board	Strategy work plan Development of strategic plan for integrated care Joint Delivery Board and Bipartite Service Groups to manage safe NMGH disaggregation. Agreed framework for the management of NMGH disaggregation (strategic intent, exit plans).	Ensuring Group Transformation plans and local hospital/MCS are aligned	Clear prioritisation of focus areas via Operational Readiness Authority	Ongoing	On track
		Alignment of strategic plans across MFT	Clear agreement on priority strategy programmes for 23/24	June 23	On track

Sources of Assurance (negative/positive/inconclusive)						Gaps/weakness in Assurance	Actions being taken to address gaps/weaknesses	Target date	Progress
Site/MCS/LCO assurance		Group assurance		External Assurance					
Routine	Received since last report	Routine	Received since last report	Routine	Received since last report				
Operational Readiness Authority Pathway Councils Hospital/MCS Post Live Readiness Assessments, including post live metrics AOF strategy domain Annual Plan reviews		Hive Stabilisation Board EPR Programme Board End of year reviews Pathway Council Oversight Committee Post Live Readiness Assessments, including post live metrics Single Service Boards established Single Service management arrangements in place Year-end Annual Plan review Minutes of GSSC Board Strategic Development updates Disaggregation report to Single Service Board	Reports to EDTC on single service and disaggregation Audit Committee (20/6): Annual report 2022/23	Deloitte – Hive Gateway reviews		Disaggregation report to SSB is verbal	Provide written report from July onwards	July 2023	On track
						Disaggregation corporate risk	Consolidated view of disaggregation risks and development of a corporate risk	July 2023	On track

Group Risk Appetite Statement

We have established, and continuously assess, the nature and extent of the principal risks that our organisation is exposed to, and is willing to take, to achieve our strategic aims - our risk appetite. We ensure that planning and decision-making reflect this assessment.

Our risk appetite is a balance that supports taking measured, assessed risk in the pursuit of certain strategic aims whilst managing and minimising risk in all operational functions. Acceptance of some calculated risk is often necessary to foster innovation and development.

We recognise that the challenging financial and operational environment that currently exists across the NHS inevitably means that, overall, there is a higher than ever inherent level of risk to the achievement of our strategic aims.

We are confident in setting our levels of risk appetite because we believe that our controls, forward scanning, and our systems designed to identify and respond to risk, are effective, and are supported by strong governance.

Our risk appetite statement is as follows:

We hold safety, quality of care, the experience of our patients and those who use our services, in the highest regard and we are measured in our approach, taking carefully considered risks that do not directly compromise the quality and safety of the care we provide.

We are prepared to accept the possibility of a short-term impact on operational performance outcomes where there is a potential for longer-term rewards, supporting innovation in the way we address our performance challenges, internally and with system partners. However, we will ensure that appropriate controls are in place to ensure that we maintain the essential standards of quality, safety and patient experience.

We follow regulatory standards and are averse to compromising compliance with them. Should circumstances require it, we are prepared to tolerate the possibility of limited derogation from a regulatory standard on a temporary basis, having assessed the risk and put in place appropriate mitigation'

We are prepared to take limited risks with regards to the experience of our workforce. When attempting to innovate, we seek to understand where similar actions have been successful elsewhere before taking any decisions.

We are prepared to accept the possibility of some workforce risk, as a direct result from change and innovation, providing there is the potential for improved recruitment and retention, and developmental opportunities for our people.

We will invest in our infrastructure plans, within our financial resources, for the best possible return for our patients, our people and the organisation as a whole, recognising that the potential for substantial gain outweighs inherent risks.

We are prepared to accept some financial risk providing appropriate controls are in place. We have a holistic understanding of value for money which is demonstrated through the contextualization of finance-related performance measures with other measures of performance in the Integrated Performance Report.

We will consistently work in partnership across the health and care system for the best possible return for our communities, with a significant appetite for challenging the status quo

We seek to lead the way in terms of our research and innovation capability and capacity. We intend to use our optimised research and innovation capability and capacity to use it as a catalyst to drive positive change across our organisation.

We seek to lead the way and will prioritize new and innovative service delivery models, even in emerging fields. We will consistently and constructively challenge our current working practices, and those of system partners, to optimise our opportunities for transformation and service integration.

Board Assurance Framework Legend

Term	Meaning
Principal risk	A high-level risk which threatens achievement of a strategic aim
Initial risk score	Risk score without the application of any mitigation or additional controls
Current risk score	Risk score at time of population of the BAF based on effectiveness of mitigation and additional controls
Residual risk score	Risk score when all planned mitigation has been effectively applied
Target risk score	Target risk score based on risk appetite
Controls	Controls/systems in place to assist/secure management of risks associated with delivery of the strategic aims
Enablers	Supportive strategies/programmes which enable delivery of the strategic aims threatened by the principal risk
Gaps in controls/enablers	Gaps in the effectiveness of the controls or enablers
Sources of assurance	Evidence in relation to the effectiveness of the controls/systems we are relying on
Positive assurance	Evidence of progress towards achievement of strategic aims
Negative assurance	Evidence of progress towards achievement of strategic aims being compromised
Gaps in assurance	Opportunities to improve the evidence about the effectiveness of the key controls being relied upon
Risk appetite	The level of risk the organisation is prepared to tolerate in relation to each principal risk
Rationale for assurance	The rationale for the Group Executive Director's rating of delivery of the strategic aim
Current assurance level	The Group Executive Director's current confidence in successful delivery of the strategic aim: Red: At risk of not making progress towards delivery of the strategic aim Amber: Some evidence of progress towards delivery of strategic aim but challenges remain Green: On track to deliver the strategic aim

Risk Matrix					
Consequence (B)	**Likelihood (A)**				
	1 Rare	2 Unlikely	3 Possible	4 Likely	5 Certain
5 Catastrophic	Score 5	Score 10	Score 15	Score 20	Score 25
4 Major	Score 4	Score 8	Score 12	Score 16	Score 20
3 Moderate	Score 3	Score 6	Score 9	Score 12	Score 15
2 Minor	Score 2	Score 4	Score 6	Score 8	Score 10
1 Negligible	Score 1	Score 2	Score 3	Score 4	Score 5

Agenda Item 11.7

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business and Trust Board Secretary
Date of paper:	July 2023
Subject:	Terms of reference for the Strategic Projects Scrutiny Committee
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	In the absence of a robust and comprehensive Governance Framework, the opportunities for supporting and enhancing organisational governance by using a body of good practice outcomes and evidence would be compromised.
Recommendations:	The Board of Directors is asked to approve the terms of reference for the Strategic Projects Scrutiny Committee.
Contact:	Name: Nick Gomm, Director of Corporate Business and Trust Board Secretary Tel: 0161 276 4841

1. Introduction

1.1 As a result of a number of current and planned major strategic projects, it has been agreed to establish a Strategic Projects Scrutiny Committee as a committee of the Board of Directors.

1.2 The committee will enable Board scrutiny of the major projects which contribute to the delivery of the Trust's strategic aims. It will track project delivery from Outline Business Case through to completion. Projects in scope of the Committee will include those which will have a significant impact on the services provided to patients and those requiring a capital spend of over £15m. The SPSC will confirm the projects within its scope at the beginning of each financial year.

1.3 The draft terms of reference for the committee are included in Appendix A.

2. Recommendations

2.1 The Board of Directors is asked to approve the terms of reference for the Strategic Projects Scrutiny Committee.

Appendix A

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

Strategic Projects Scrutiny Committee

TERMS OF REFERENCE

1. CONSTITUTION

The Strategic Projects Scrutiny Committee (SPSC) has been formally constituted by the Board of Directors in accordance with its Standing Orders.

2. MEMBERSHIP

The membership of the SPSC will consist of:

- Group Non-Executive Director (Chair)
- Group Non-Executive Directors
- Group Executive Directors

The Director of Strategic Projects, together with members of their team and such other leads for major projects as may be reasonably required, will also attend each meeting.

The Trust Board Secretary (or nominated deputy) shall be secretary to the Committee and shall attend to take minutes of the meetings and provide appropriate support to the Chair and Committee members.

Other members will be co-opted on to, or invited to attend, the SPSC as necessary.

3. QUORACY

No business should be transacted at a meeting unless at least the following members are present

- NED Chair (or nominated deputy)
- Two Group Non-Executive Directors
- Two Group Executive Directors

4. FREQUENCY OF MEETINGS

The SPSC will initially meet every three months. This frequency may be subject to review within the annual timeframe for review in response to the needs of specific projects.

5. OVERVIEW

The SPSC has been established to enable Board scrutiny of the major projects which contribute to the delivery of the Trust's strategic aims. It will track project delivery from Outline Business Case through to completion. Projects in scope of the Committee will include those which will have a significant impact on the services provided to patients and those requiring a

capital spend of over £15m. The SPSC will confirm the projects within its scope at the beginning of each financial year.

6. SCOPE AND DUTIES

The scope and duties of the SPSC are:

- To identify major projects to be considered through the SC
- To monitor the development of business cases associated with identified major projects
- To monitor the delivery of the major projects; scrutinise performance against the key deliverables and review actions and mitigation plans including timescales.
- To monitor the benefits realisation plans and the readiness of the organisation to deliver benefits to plan and timescale pre and post implementation
- To oversee individual large contracts associated with each project
- To explore the potential impact of emerging or identified significant risks in relation to Programme delivery, implementation and realisation of associated benefits and report to other relevant scrutiny committees or the Board Directors as appropriate.
- To gain assurance about the overall governance arrangements of the programmes and undertake regular and appropriate review of the effectiveness of these arrangements.
- Where appropriate, to receive and consider assurance reports on the major projects from external bodies.

The Committee/Group will constitute sub-committees or sub-groups, as required, to support delivery of its duties.

7. AUTHORITY

The SPSC is empowered to examine and investigate any activity within the Group or Hospitals/MCSs/LCOs pursuant to the above scope and duties.

8. REPORTING

The SPSC will provide a report/minutes to the Bord of Directors and the Audit Committee after each meeting.

9. REVIEW

These Terms of Reference will be reviewed at least annually.

10. KEY PERFORMANCE INDICATORS

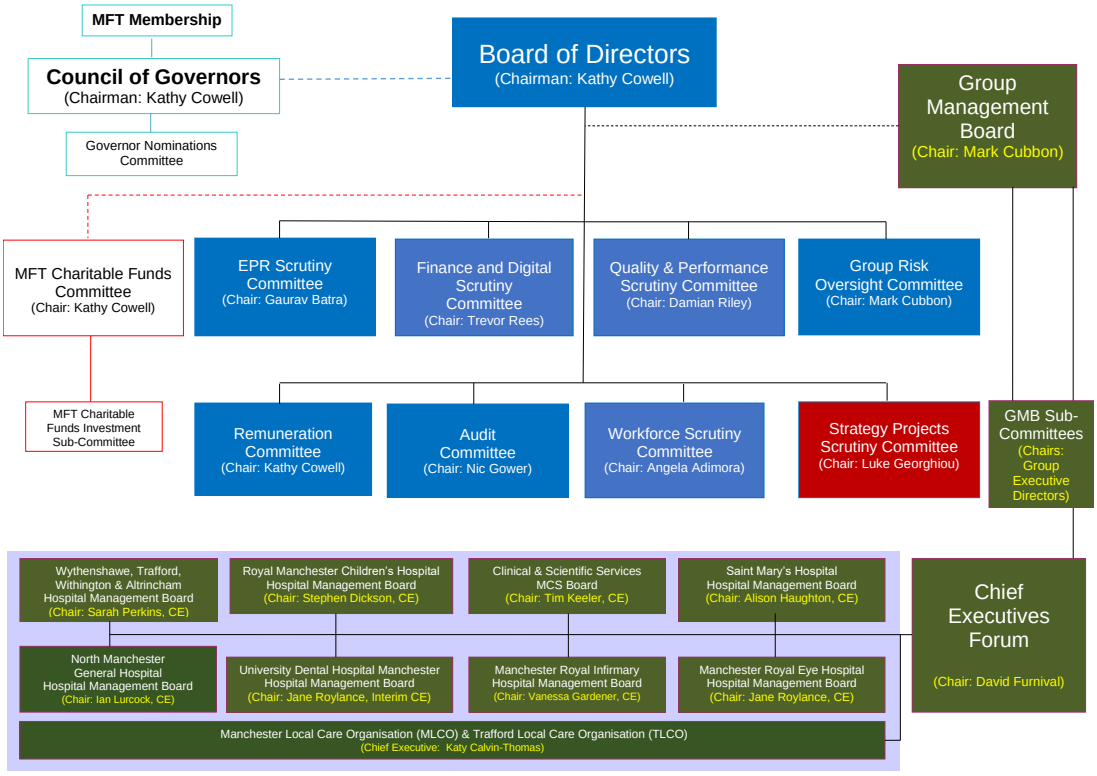
These Terms of Reference will be measured against the following key performance indicators:

- 75% attendance of all listed members or nominated deputy
- 100% coverage of duties over a 12 month period
- 100% of scheduled meetings take place
- a Committee work programme is in place
- training needs of the participants will be identified and relevant training provided

11. SUB-COMMITTEES/SUB-GROUPS

Updates from the relevant major projects governance structures will be provided to the Committee at each meeting.

12 . REPORTING STRUCTURE CHART (see overleaf)



Agenda Item 11.8

MANCHESTER UNIVERSITY NHS FOUNDATION TRUST

BOARD OF DIRECTORS (PUBLIC)

Report of:	Group Executive Director of Workforce and Corporate Business
Paper prepared by:	Nick Gomm, Director of Corporate Business and Trust Board Secretary
Date of paper:	July 2023
Subject:	Review of MFT's Constitution
Purpose of Report:	Indicate which by ✓ • Information to note • Support • Accept • Resolution • Approval ✓ • Ratify
Consideration against the Trust's Vision & Values and Key Strategic Aims:	Foundation Trusts are required to have a constitution which sets out the governance arrangements for the organisation. This review of MFT's constitution ensure it reflects recent amendments to legislation.
Recommendations:	The Board of Directors is asked to approve the amendments to MFT's Constitution
Contact:	Name: Nick Gomm, Director of Corporate Business and Trust Board Secretary Tel: 0161 276 4841

1. Introduction

All NHS Foundation Trusts (NHS FTs) are required to have a Constitution. Monitor's Model Constitution (latest version issued in 2014) sets out the key provisions to be incorporated and forms the basis by which NHS FT Constitutions are developed. To date, a new Model Core Constitution for FTs has not been published therefore key elements of the existing 2014 model have been retained.

It is best practice to undertake regular reviews to ensure current requirements are incorporated with the recent enactment of the Health and Care Act (2022) being the key contributing factor triggering this constitutional process. Prior to this, the last review occurred in 2021 to incorporate updates as part of the NMGH acquisition.

The current review has been undertaken by an external legal firm Browne Jacobson (supported by officers of the Trust). As part of this process, officers also reviewed several other FT Constitutions alongside incorporating key elements of the new Code of Governance (October 2022) and associated Addendum to the Reference Guide for NHS Foundation Trust Governors (October 2022).

The review has found that several updates are required to be in keeping with the new Health and Care Act (2022).

Of note, amendments are to be approved by a majority of both the Board of Directors and the Council of Governors respectively. In addition, amendments of the Trust's Constitution are to be notified to NHS England (NHSE). For the avoidance of doubt, NHSE do not have the power or duty to determine whether the Trust's Constitution accords with Schedule 7 of the NHS Act (2006).

Any amendments to the Constitution will have immediate effect as long as they are legally compliant. However, if the amendments relate to the powers or duties of Governors they will cease to have effect if they are not approved at the next Annual Members' Meeting. Legal advice has confirmed that none of the proposed changes made require the approval of members and that they all accord with Schedule 7 of the NHS Act (2006).

2. Changes to the Constitution

A revised draft Constitution (June 2023) has been developed and can be found in Appendix A. The following outlines the overall key proposed changes to the Constitution to be in keeping with the NHS Act (2006) as amended by Health and Social Care Act (2012) and Health and Care Act (2022):

- General housekeeping to reformat some wording (grammatical errors/typos) and key provisions in the appendices to enable the document to become more user-friendly e.g. 'Further Provisions as to Meetings of Governors' and 'Declaration' moved out of Annex 5 (Additional Provisions – Council of Governors) to Annex 6 (Standing Orders for the Practice and Procedure of the Council of Governors), *paragraphs 18 -18.9 pages 39 & 40*, 'Model Election Rules' moved to Appendix 10 *(page 79)* (from Appendix 4), aggregate number of public governors required added into main part of Constitution (*under section 12.2, page 10*) with duplications of definitions being removed throughout the entire document *(removed throughout document including appendices).*

- New requirements incorporated to reflect current legislation/Health and Care Act 2022 including:

    - Definitions, references and powers/duties in relation to the new Act (2022) and associated bodies added i.e. NHS England, Integrated Care Board alongside old bodies removed i.e. Manchester Care Commissioning Group, NHS Improvement, Monitor etc. plus references to EU laws *(updates made throughout document)*
    - Casting vote provisions removed in relation to the presiding Chair as part of Council of Governors' Meetings *(removed so no longer forms part of paragraph 18.6, page 40)*
    - Special Members' Meeting provision removed with reference made to hold members' engagement events/meetings *(removed so no longer forms part of paragraphs 4&5, page 30 & paragraph 7.1, page 31 with provision added to paragraph 3.4, page 74)*
    - To clearly outline Governors expanded duty to represent and take account of the interests of the public at large *(provision added to paragraph 3.17.1 page 50 & paragraph 3.4.1, page 70)*
    - Clarity around decision-making validity in the event of appointment defects *(provision added to paragraph 47, page 26)*
    - To update Nominated Governor role to reflect new GM Integrated Care Board (remove old Manchester Care Commissioning Group) *(replaced in Table - Appointed Governors Section, page 29)*
    - Public questions provision removed in relation to Executive Directors at Council of Governors Meetings alongside reference to pre-recorded materials constituting presence at meetings *(removed so no longer forms part of paragraph 5, page 36 & paragraph 18.5, page 39)*
    - To outline Nominations Committee role and Council of Governors approval in relation to the appointment of Group Deputy Chair *(provisions added to paragraph 27.1, page 15 & paragraphs 3.4.1, 3.4.2 & 3.4.4, page 47)*
    - Provisions made to reflect updated guidance around the Trust's licence/Fit and Proper Person's definitions *(updated provision paragraph 29.1.7, page 16, & paragraph 8.9, page 32)*
    - Provisions added to outline Audit Committee Chair requirements *(provisions added to paragraph 39.2 & 39.3, page 22)*
    - Provisions added to reflect updated guidance for Group Chairman and Group Non-Executive Director terms of office *(paragraph 3.3.4 & 3.3.5, page 47).*
    - Private minutes (part 2) of the Board of Directors' Meeting – provisions to be updated to make them available to the Council of Governors *(paragraph 4.15.2, page 55)*

- Additional provisions included to capture Board and/or Governor eligibility/disqualification requirements and procedures incorporated in other NHS FT Constitutions:

    - To clearly define some provision wording to prevent avoidance of doubt i.e. moving between public constituencies requires a Public Governor to step down *(provision added to paragraph 14.2, page 11)*
    - Debt relief order disqualification for Board and Governor members *(provision added to paragraph 15.1.2, page 12 & paragraph 29.1.2, page 16)*

  - Staff disqualification from Governor members if suspended and/or subject to final written warning *(provisions added to paragraph 8.13, page 32)*
  - Disqualification from Governor members if vexatious complainant *(provisions added to paragraph 8.14, page 33)*
  - To make provision for Lead Governor's tenure to be a maximum of two terms of office, except in exceptional circumstances agreed by the Chairman of the Council of Governors. *(provisions added to paragraphs 7.5, page 31)*
  - Governor panel arrangements to support investigation procedure for Governors *(provisions added to a new annex 9, pages 77 – 78)*
  - Wording amended to make clear the support options available to the Group Chair, Group Deputy Chair or a Group NED, when the presiding Chair has a conflict of interest at Council of Governor Meetings i.e. Lead Governor may support the discussions for that part of the meeting *(provisions added to paragraph 17.1, page 13).*

- Other
  - Arbitrator in Governor/Board dispute to be nominated by NHSE (remove reference to ACAS) *(provision revised in paragraph, 7.1.4, page 72).*
  - Footnote added to outline that NHSE Panel is disbanded at the current date *(footnote added to paragraph 19.2, page 13).*
  - Additional wording to simply the sealing of Trust documents *(provision added to paragraph 43.2, page 24).*
  - Additional disqualification provision to support a more equitable and diverse range of candidates to be made available and voted upon by members giving new candidates a more balanced chance of being elected alongside preventing candidates from standing that are already holding a Governor role i.e. if currently a Governor or previously been a Governor of an NHS Foundation Trust other than the Trust, unless the Group Chairman decides that they may become or continue as a Governor *(provisions added to paragraphs 8.12, page 32).*

3. Next steps

Following Board approval, the Council of Governors will be asked to approve the amended Constitution at their meeting on the 12th July 2023. Upon approval, NHSE will notified of the changes. A key overview will also be provided to Members (as part of the Membership newsletter to be circulated early September 2023).

4. Recommendations

The Board of Directors is asked to approve the changes to the Trust's Constitution as outlined in the paper, to reflect the Health and Care Act 2022 alongside other key governance recommendations.

Appendix A

Appendix A

Manchester University NHS Foundation Trust (MFT)

Constitution

- JUNE 2023 -

Table of Contents

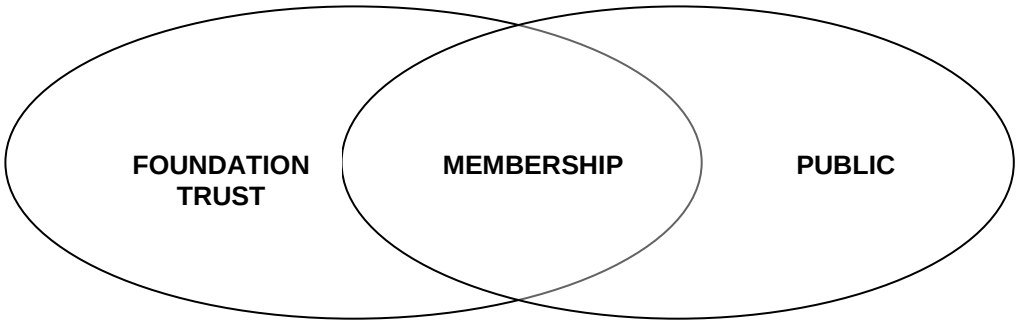
Introduction

An NHS Foundation Trust has more financial and operational freedoms than conventional NHS Trusts. However, Foundation Trusts are still firmly part of the NHS and subject to NHS standards, performance ratings and systems of inspection with their primary purpose being to provide NHS care to NHS patients according to NHS quality standards and principles i.e. free care based on need, not ability to pay.

Foundation Trusts were first introduced in April 2004 and are based upon the mutual organisation model in that those living in communities served by the Foundation Trust can become members. From these members, Governors are elected to represent members' interests in the running of the organisation. Members are therefore given a bigger say in the management and provision of services. By this method, Foundation Trusts provide greater accountability to patients, service users, local people and NHS staff with the overriding principle being that members have a sense of ownership over the services that a Foundation Trust provides. Foundation Trusts therefore have a duty to engage with their local communities and encourage local people to become members of their organisation.

Foundation Trusts are regulated by NHS England and are subject to inspections by the Care Quality Commission.

The diagram below highlights the relationship between a Foundation Trust and the communities it serves: -



1. Interpretation and Definitions

1.1 Unless otherwise stated, words or expressions contained in this Constitution shall bear the same meaning as in the National Health Service Act 2006 as amended.

1.2 Words importing the masculine gender only shall include the feminine gender; words importing the singular shall import the plural and vice-versa

1.3 Definitions in this Constitution:

'2006 Act'	National Health Service Act 2006
'2012 Act'	Health and Social Care Act 2012
'2022 Act'	Health and Care Act 2022
'Accounting Officer'	is the Group Chief Executive, who from time to time discharges the functions as Accounting Officer of the Trust for the purposes of Government accounting as specified in paragraph 25(5) of Schedule 7 to the 2006 Act
'Annual Members Meeting'	is defined in paragraph 11 of the Constitution
'Appointed Governor'	is a Governor who has been appointed by stakeholder organisations to represent the interests of their organisations in the local community
'Board of Directors or **Board'**	is the Board of Directors of the Trust as constituted pursuant to this Constitution and the 2006 Act
'Consecutive Years'	are one year followed by another year unless there is a period not less than 12 months between them
'Constitution'	this Constitution that has effect in accordance with Section 56(11) of the 2006 Act and the Annexes to it
'Council of Governors'	is the Council of Governors of the Trust as constituted pursuant to this Constitution
'Directors'	are the Group Chairman, the Group Executive Directors and the Group Non-Executive Directors
'Elected Governor'	is a Governor who has been elected in accordance with this Constitution

'Governor'	is an individual who is a member of the Council of Governors
'Group Chairman' or 'Group Chair'	is the individual appointed as Group Chairman of the Board of Directors (and Chair of the Council of Governors) in accordance with paragraph 26.1 of this Constitution
'Group Chief Executive'	is the individual appointed as Group Chief Executive of the Trust in accordance with paragraph 17(3) of Schedule 7 to the 2006 Act and paragraph 28.1 of this Constitution
'Group Deputy Chair' or 'Group Deputy Chairman'	is the Group Non-Executive Director appointed as Group Deputy Chairman in accordance with paragraph 27 of this Constitution
'**Group Executive Director**'	is the Group Chief Executive or an individual appointed as a Group Executive Director of the Trust in accordance with paragraph 28.3 of this Constitution
'Group Non-Executive Director'	is an individual appointed as a Group Non-Executive Director of the Trust in accordance with paragraph 25 of this Constitution
'Integrated Care Board' or 'ICB'	means an integrated care board established under Chapter A3 of Part 2 of the 2006 Act
'Licence'	means the Trust's provider licence number **130164** issued by Monitor on **1st October 2017**
'Local Authority Governor'	is a Governor appointed by a Local Authority (which for the avoidance of doubt is not to mean a Councillor of a Local Authority)
'Member'	is an individual registered as a member of one of the constituencies described at paragraph 5 and at Annex 1 and Annex 2 of this Constitution
'NHS England'	is the body corporate known as NHS England, established under section 1H of the 2006 Act
'Officer'	is an employee of the Trust or any person holding a paid appointment of office with the Trust
'Register of Members'	is a register of members which the Trust is required to have and maintain under Paragraph 20 of Schedule 7 of the 2006 Act

'Secretary'	is the individual appointed by the Group Chairman and Group Chief Executive as the Secretary
'Significant Transaction'	is defined in paragraph 45.3 of this Constitution
'Statutory Transaction'	is a merger under s56 of the 2006 Act or an acquisition under s56A of the 2006 Act or a separation under s56B of the 2006 Act or a dissolution under s57A of the 2006 Act
'Trust'	Manchester University NHS Foundation Trust

1.4 Save as otherwise permitted by law, the Group Chairman shall be the final authority for all purposes on the interpretation of this Constitution (on which he/she should be advised by the Group Chief Executive and/or Secretary).

2. Name

2.1 The name of the Trust is:

Manchester University NHS Foundation Trust (MFT)

3. Principal Purpose

3.1 The principal purpose of the Trust is the provision of goods and services for the purposes of the Health Service in England.

3.2 The Trust does not fulfill its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

3.3 The Trust may provide goods and services for any purposes related to:

3.3.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

3.3.2 the promotion and protection of public health.

3.4 The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose.

4. Powers

4.1 The powers of the Trust are set out in the 2006 Act.

4.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

4.3 Any of these powers may be delegated to a Committee of Directors or to a Group Executive Director.

4.4 The Trust shall exercise its functions effectively, efficiently and economically.

4.5 Subject to paragraph 4.6 below and having regard to any guidance published by NHS England, in making a decision about the exercise of its functions, the Trust shall have regard to all likely effects of the decision in relation to:

4.5.1 the health and wellbeing of the people of England;

4.5.2 the quality of services provided to individuals by relevant bodies, or in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England; and

4.5.3 efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

4.6 The requirement to have regard to the wider effect of its decisions set out at paragraph 4.5 shall not apply to decisions about services to be provided to a particular individual for or in connection with the prevention, diagnosis or treatment of illness.

4.7 In paragraph 4.5 ‘relevant bodies’ has the meaning set out in paragraph 63A(4) of the 2006 Act.

4.8 In exercising its functions, the Trust shall have regard to the need to contribute towards compliance with the UK net zero emissions target set out at section 1 of the Climate Change Act 2008 and the environmental targets set out at section 5 of the Environment Act 2021, and to adapt to any current or predicted impacts of climate change identified in the most recent report under section 56 of the Climate Change Act 2008. In doing so, the Trust shall also have regard to guidance published by NHS England.

4.9 The Trust may do anything which appears to it to be necessary or expedient for the purposes of or in connection with its functions.

4A Joint working and delegation arrangements

4A.1 Subject to paragraph 4A.2 the Trust may arrange in accordance with s65Z5 of the 2006 Act for the joint exercise of functions with any one or more of the following bodies:

4A.1.1 a relevant body;

4A.1.2 a local authority;

4A.1.3 a combined authority.

4A.2 Where the Trust has entered into arrangements for the joint exercise of functions with one or more bodies in accordance with paragraph 5A.1, it may make arrangements for:

4A.2.1 the function to be exercised by a joint committee of theirs

4A.2.2 for one or more of them, or a joint committee of them, to establish and maintain a pooled fund.

4A.3 The Trust must have regard to any guidance published by NHS England under s65Z7.

4A.4 In this paragraph 4A the following terms have the following meanings:

4A.4.1 'Relevant body' has the meaning set out in section 65Z5(2) of the 2006 Act

4A.4.2 'Local authority' means a local authority within the meaning of section 2B of the 2006 Act

4A.4.3 'Combined authority' has the meaning set out in s275 of the 2006 Act

4A.4.4 'Pooled fund' has the meaning set out in s65Z6(3) of the 2006.

4B Duties relating to Integrated care system financial controls

4B.1 The Trust must seek to achieve financial objectives that apply to it under section 223L of the 2006 Act.

4B.2 The Trust must exercise its functions with a view to ensuring that it complies with its duties:

4B.2.1 under s223LA of the 2006 Act to limit expenditure

4B.2. under s223M and s223N of the 2006 Act to limit local capital resource use and local revenue resource use.

5. Membership and Constituencies

5.1 The Trust shall have members, each of whom shall be a member of one of the following constituencies:

5.1.1 a public constituency

5.1.2 the staff constituency.

6. Application for Membership

6.1 An individual who is eligible to become a member of the Trust may do so on application to the Trust in accordance with this Constitution subject to paragraph 7, 8 and 9.

6.2 Where an individual applies to become a member of the Trust, once received and accepted by the Trust, the applicant's details will be entered into the Trust's Register of Members.

7. Public Constituency

7.1 An individual who lives in the area specified in Annex 1 as an area for a public constituency may become or continue as a member of the Trust.

7.2 Those individuals who live in an area specified for a public constituency are referred to collectively as a Public Constituency.

7.3 The Trust has five Public Constituencies:

7.3.1 Manchester
7.3.2 Trafford
7.3.3 Rest of Greater Manchester
7.3.4 Eastern Cheshire
7.3.5 Rest of England & Wales.

7.4 The minimum number of members in each Public Constituency is specified in Annex 1 (The Public Constituencies).

8. Staff Constituency

8.1 An individual who is employed by the Trust under a contract of employment with the Trust may become or continue as a member of the Trust provided:

8.1.1 he is employed by the Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or

8.1.2 he has been continuously employed by the Trust under a contract of employment for at least 12 months.

8.2 Individuals who exercise functions for the purposes of the Trust, otherwise than under a contract of employment with the Trust, may become or continue as members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. For the avoidance of doubt this does not include individuals who assist or provide services to the Trust on a voluntary basis.

8.3 Those individuals who are eligible for membership of the Trust by reason of the previous provisions are referred to collectively as the Staff Constituency.

8.4 The Staff Constituency shall be divided into four descriptions of individuals who are eligible for membership of the Staff Constituency:

8.4.1 Medical and Dental
8.4.2 Nursing and Midwifery
8.4.3 Other Clinical
8.4.4 Non-Clinical and Support.

8.5 The minimum number of members in each class of the Staff Constituency is specified in Annex 2 (The Staff Constituency).

9. Automatic Membership by Default (Staff)

9.1 An individual who is:

9.1.1 eligible to become a member of the Staff Constituency; and

9.1.2 invited by the Trust to become a member of the Staff Constituency and a member of the appropriate class within the Staff Constituency,

shall become a member of the Trust as a member of the Staff Constituency and appropriate class within the Staff Constituency without an application being made, unless he informs the Trust that he does not wish to do so.

10. Restriction on Membership

10.1 An individual who is a member of a constituency, or of a class within a constituency, may not while membership of that constituency or class continues, be a member of any other constituency or class.

10.2 An individual who satisfies the criteria for membership of the Staff Constituency may not become or continue as a member of any constituency other than the Staff Constituency.

10.3 An individual must be at least 11 years old to become a member of the Trust.

10.4 Further provisions as to the circumstances in which an individual may not become or continue as a member of the Trust are set out in Annex 7 (Further Provisions).

11. Annual Members' Meeting

11.1 The Trust shall hold an annual meeting of its members ('Annual Members' Meeting'). The Annual Members' Meeting shall be open to members of the public.

11.2 Further provisions about the Annual Members' Meeting are set out in Annex 8 (Annual Members' Meeting).

12. Council of Governors (Composition)

12.1 The Trust is to have a Council of Governors, which shall comprise both Elected Governors and Appointed Governors.

12.2 The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

12.3 The composition of the Council of Governors is specified in Annex 3 (Composition of the Council of Governors).

12.4 The Governors, other than the Appointed Governors, shall be chosen by election by their constituency or, where there are classes within a constituency, by their class within that constituency. The number of Elected Governors to be elected by each constituency, or, where appropriate, by each class of each constituency, is specified in Annex 3 (Composition of the Council of Governors).

13. Council of Governors (Election of Governors)

13.1 Elections for Elected Governors shall be conducted in accordance with the Model Election Rules on the basis of single transferable vote (STV) polling and the Model Election Rules shall be construed accordingly.

13.2 The Model Election Rules as published by NHS Providers form part of this Constitution. The Model Election Rules current at the date of their adoption under this Constitution are attached at Annex 10 (Model Election Rules, 2014).

13.3 A subsequent variation of the Model Election Rules by NHS Providers or the Department of Health and Social Care shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 44 of the Constitution (amendment of the Constitution).

13.4 An election, if contested, shall be by secret ballot.

14. Council of Governors (Tenure)

14.1 An Elected Governor may hold office for a period of up to three years. The period of office shall be known as the term.

14.2 An Elected Governor shall cease to hold office if he ceases to be a member of the constituency or class by which he was elected. For the avoidance of doubt, this includes a Governor moving their principal residence from one public constituency to another.

14.3 Subject to 14.4 an Elected Governor shall be eligible for re-election at the end of his term.

14.4 An Elected Governor may not hold office for more than three terms or a maximum of nine consecutive years, whichever is the shorter in duration, and shall not be eligible for re-election if he has already held office for more than six consecutive years.

14.5 An Appointed Governor may hold office for a period of up to three years.

14.6 An Appointed Governor shall cease to hold office if the appointing organisation withdraws its sponsorship of him (terminates the appointment). An Appointed Governor shall be eligible for re-appointment at the end of his term subject to 14.7.

14.7 An Appointed Governor may not hold office for more than three terms or nine Consecutive Years, whichever is the shorter in duration, and shall not be eligible for re-appointment if he has already held office for more than six Consecutive Years.

14.8 Further provisions as to the tenure for Governors, is set out at Annex 4 (Additional Provisions – Council of Governors).

15. Council of Governors (Disqualification and Removal)

15.1 The following may not become or continue as a Governor:

15.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged;

15.1.2 a person in relation to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986;

15.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it;

15.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

15.2 Governors must be at least 16 years of age at the date they are nominated for election or appointment.

15.3 Further provisions as to the circumstances in which an individual may not become or continue as a Governor and for the removal of Governors are set out in Annex 5 (Additional Provisions – Council of Governors).

16. Council of Governors (Duties of Governors)

16.1 The general duties of the Council of Governors are:

16.1.1 to hold the Group Non-Executive Directors individually and collectively to account for the performance of the Board of Directors, and

16.1.2 to represent the interests of the members of the Trust as a whole and the interests of the public.

16.2 The Trust must take steps to secure that the Governors are equipped with the skills and knowledge they require in their capacity as such.

16.3 Further provisions about the duties of Governors are set out in Annex 7 (Further Provisions).

17. Council of Governors (Meetings of Governors)

17.1 The Group Chairman or, in his absence the Group Deputy Chairman or, in his absence, one of the Group Non-Executive Directors, shall preside at meetings of the Council of Governors. If the person presiding at any such meeting has a conflict of interest in relation to the business being discussed, the Lead Governor of the Council of Governors may support the Group Chairman, Group Deputy Chairman or a Group Non-Executive Director in the discussions for that part of the meeting (as appropriate).

17.2 Meetings of the Council of Governors shall be open to members of the public. Members of the public may be excluded from all or part of a meeting for special reasons (in accordance with the Council of Governors Standing Orders – Annex5).

17.3 For the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or Directors' performance), the Council of Governors may require one or more of the Directors to attend a meeting.

17.4 Further provisions about Council of Governors' Meetings are set out in Annex5 (Standing Orders for the Practice and Procedure of the Council of Governors).

18. Council of Governors (Standing Orders)

18.1 The Standing Orders for the practice and procedure of the Council of Governors are attached at Annex 5 (Standing Orders for the Practice and Procedure of the Council of Governors).

19. Council of Governors (Referral to the Panel)

19.1 In this paragraph, the Panel means a panel of persons appointed by NHS England to which a Governor of an NHS Foundation Trust may refer a question as to whether the Trust has failed or is failing:

19.1.1 to act in accordance with its Constitution, or

19.1.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

19.2 A Governor may refer a question to the Panel only if more than half of the members of the Council of Governors voting approve the referral[1].

1 The panel has been disbanded as at July 2023

20. Council of Governors (Conflicts of Interest of Governors)

20.1 If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of

the Council of Governors as soon as he becomes aware of it. The Standing Orders for the Council of Governors (Annex 5) shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed.

21. Council of Governors (Travel Expenses)

21.1 The Trust may pay travelling and other expenses to members of the Council of Governors at rates determined by the Trust.

22. Council of Governors (Further Provisions)

22.1 Further provisions with respect to the Council of Governors are set out in Annex 4 (Additional Provisions – Council of Governors).

23. Board of Directors (Composition)

23.1 The Trust is to have a Board of Directors, which shall comprise both Group Executive and Group Non-Executive Directors.

23.2 The Board of Directors is to comprise:

23.2.1 the Group Chairman.

23.2.2 a minimum of five other Group Non-Executive Directors; and

23.2.3 a minimum of five Group Executive Directors

23.3 One of the Group Executive Directors shall be the Group Chief Executive.

23.4 The Group Chief Executive shall be the Accounting Officer.

23.5 One of the Group Executive Directors shall be the Group Chief Finance Officer.

23.6 One of the Group Executive Directors is to be a registered medical practitioner or a registered dentist (within the meaning of the Dentists Act 1984).

23.7 One of the Group Executive Directors is to be a Registered Nurse or a Registered Midwife.

23.8 The number of the Directors may be increased provided always that at least half of the Board, excluding the Group Chairman, comprises Group Non-Executive Directors.

24. Board of Directors (General Duty)

The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

25. Board of Directors (Qualification for Appointment as a Group Non-Executive Director)

25.1 A person may be appointed as a Group Non-Executive Director only if:

25.1.1 he is a member of a Public Constituency, or

25.1.2 where any of the Trust's hospitals includes a medical or dental school provided by a university, he exercises functions for the purposes of that university, and

25.1.3 he is not disqualified by virtue of paragraph 29 below.

26. Board of Directors (Appointment and Removal of Group Chairman and other Group Non-Executive Directors)

26.1 The Council of Governors at a general meeting of the Council of Governors shall appoint or remove the Group Chairman of the Trust and the other Group Non-Executive Directors.

26.2 Removal of the Group Chairman or another Group Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

26.3 The Council of Governors shall adopt a procedure for appointing/removing the Group Chairman and/or other Group Non-Executive Director in accordance with any guidance issued by NHS England.

26.4 Further provisions as to the appointment and removal of the Group Chairman and other Group Non-Executive Directors are set out at Annex6 (Standing Orders for the Practice and Procedure of the Board of Directors).

27. Board of Directors (Appointment of Group Deputy Chairman and Group Senior Independent Director)

27.1 The Nominations Committee shall, following consultation with the Council of Governors, appoint one of the Group Non-Executive Directors as Group Deputy Chairman.

27.2 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Group Non-Executive Directors as a Group Senior Independent Director to act in accordance with NHS England's Code of Governance for NHS Provider Trusts (as may be amended and replaced from time to time); and the Trust's Standing Orders.

28. Board of Directors (Appointment and Removal of the Group Chief Executive and other Group Executive Directors)

28.1 The Group Non-Executive Directors shall appoint or remove the Group Chief Executive.

28.2 The appointment of the Group Chief Executive shall require the approval of the Council of Governors.

28.3 A committee consisting of the Group Chairman, the Group Chief Executive and the other Group Non-Executive Directors shall appoint or remove the other Group Executive Directors.

29. Board of Directors (Disqualification)

29.1 The following may not become or continue as a member of the Board of Directors:

29.1.1 a person who has been adjudged bankrupt or whose estate has been sequestrated and (in either case) has not been discharged.

29.1.2 a person in relation to whom a moratorium period under a debt relief order applies under Part 7A of the Insolvency Act 1986;

29.1.3 a person who has made a composition or arrangement with, or granted a trust deed for, his creditors and has not been discharged in respect of it.

29.1.4 a person who within the preceding five years has been convicted in the British Islands of any offence if a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine) was imposed on him.

29.1.5 A person where disclosures revealed by a Disclosure and Barring Service check against such a person are such that it would be inappropriate for him to become or continue as a Director or would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.

29.1.6 A person who is a Governor.

29.1.6 A person who is the spouse, partner, parent or child of an existing member of the Board of Directors of the Trust.

29.1.7 A person who is not a fit and proper person for the purposes of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and/or Conditions of the Trust's License

29.1.8 A person is subject of a disqualification order made under the Company Directors Disqualification Act 1986.

29.1.9 A person whose tenure of office as Chair or a member or Director of a health service body has been terminated on the grounds that their appointment is not in the interests of the health service for reasons including non-attendance at meetings, or for non-disclosure of a pecuniary interest.

29.1.10 A person who has within the preceding two years been dismissed, otherwise than by reason of redundancy or for ill health, from any paid employment with a health service body or a local authority

29.1.11 A person who is the subject of an order under the Sexual Offences Act 2003.

29.1.12 A person who is included in any barred list established under the Safeguarding Vulnerable Adults Act 2006 or any equivalent list.

29.1.13 A person who is a Director or Governor or Governing Body member or equivalent of another NHS body except with the approval of the Board of Directors for Group Executive Directors or the Council of Governors for Group Non-Executive Directors.

29.1.14 In the case of Group Non-Executive Directors, a person who no longer meets the requirements set out in paragraph 25.1.

29.1.15 In the case of the Group Non-Executive Directors, a person who has refused without any reasonable cause to fulfill any training requirement established by the Board of Directors.

29.1.16 A person who is a member of a Local Authority's Overview and Scrutiny Committee or Health and Wellbeing Board covering health matters.

30. Board of Directors (Meetings)

30.1 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

30.2 Before holding a meeting, the Board of Directors will send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors will send a copy of the minutes of the meeting to the Council of Governors.

30.3 Further provisions as to Board of Directors' Meetings are set out at Annex 6 (Standing Orders for the Practice and Procedure of the Board of Directors) .

31. Board of Directors (Standing Orders)

31.1 The Standing Orders for the practice and procedure of the Board of Directors are attached at Annex6 (Standing Orders for the Practice and Procedure of the Board of Directors).

31.2 The Board of Directors Standing Orders do not form part of this Constitution and any amendment of the Standing Orders shall not constitute an amendment of the terms of this Constitution for the purposes of paragraph 44 of this Constitution.

31.3 The Board of Directors Standing Orders may be amended in accordance with the procedure set out in Board of Directors Standing Order Annex6 (Standing Order for the Practice and Procedure of the Board of Directors). If there is any conflict between the Board of Directors Standing Orders and the Constitution, the Constitution shall prevail.

32. Board of Director (Conflicts of Interest of Directors)

32.1 The duties that a Director of the Trust has by virtue of being a Director include in particular:

32.1.1 A duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust.

32.1.2 A duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

32.2 The duty referred to in sub-paragraph 32.1.1 is not infringed if:

32.2.1 The situation cannot reasonably be regarded as likely to give rise to a conflict of interest, or

32.2.2 The matter has been authorised in accordance with the Constitution.

32.3 The duty referred to in sub-paragraph 32.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

32.4 In sub-paragraph 32.1.2, “third party” means a person other than:

32.4.1 The Trust, or

32.4.2 A person acting on its behalf.

32.5 If a Director of the Trust has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors.

32.6 If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

32.7 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

32.8 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

32.9 A Director need not declare an interest:

32.9.1 If it cannot reasonably be regarded as likely to give rise to a conflict of interest;

32.9.2 If, or to the extent that, the Directors are already aware of it;

32.9.3 If, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

32.9.3.1 By a meeting of the Board of Directors, or

32.9.3.2 By a committee of the Directors appointed for the purpose under the Constitution.

32.10 The Standing Orders for the Practice and Procedure of the Board of Directors (Annex 6) make further provisions for the disclosure of interests.

33. Board of Directors (Remuneration and Terms of Office)

33.1 The Council of Governors at a general meeting of the Council of Governors shall decide the remuneration and allowances, and the other terms and conditions of office, of the Group Chairman and the other Group Non-Executive Directors.

33.2 The Trust shall establish a Committee of Non-Executive Directors to decide the remuneration and allowances, and the other terms and conditions of office, of the Group Chief Executive and other Group Executive Directors.

34. Registers

34.1 The Trust shall have:

34.1.1 a register of members showing, in respect of each member, the constituency to which he belongs and, where there are classes within it, the class to which he belongs;

34.1.2 a register of members of the Council of Governors;

34.1.3 a register of interests of Governors;

34.1.4 a register of Directors; and

34.1.5 a register of interests of the Directors.

34.1.6 The information to be included in the above registers shall be such as will comply with the requirements of the 2006 Act, and any subordinate legislation made under it and the provisions of this Constitution.

35. Admission to and Removal from the Registers

35.1 The Secretary shall be responsible for the maintenance of, admission to and removal from the registers under the provisions of this Constitution.

35.2 Each Director and Governor shall advise the Secretary as soon as practicable of anything which comes to his attention or which he is aware of which might affect the accuracy of the matters recorded in any of the registers referred to in paragraph 34.

35.3 Members will be removed from the Register of Members if:

35.3.1 the Member is no longer eligible or is disqualified; or

35.3.2 the Member dies.

36. Registers (Inspection and Copies)

36.1 The Trust shall make the registers specified in paragraph 34 above available for inspection by members of the public, except in the circumstances set out below or as otherwise prescribed by regulations made under the 2006 Act.

36.2 The Trust shall not make any part of its registers available for inspection by members of the public which shows details of any member of the Trust, if he so requests.

36.3 So far as the registers are required to be made available:

36.3.1 they are to be available for inspection free of charge at all reasonable times; and

36.3.2 a person who requests a copy of or extract from the registers is to be provided with a copy or extract.

37. Documents Available for Public Inspection

37.1 The Trust shall make the following documents available for inspection by members of the public free of charge at all reasonable times:

37.1.1 a copy of the current Constitution,

37.1.2 a copy of the latest Annual Accounts and of any report of the auditor on them, and

37.1.3 a copy of the latest Annual Report

37.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

37.2.1 a copy of any order made under section 65D (appointment of Trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L(Trusts coming out of administration) or 65LA (Trusts to be dissolved) of the 2006 Act.

37.2.2 a copy of any report laid under section 65D (appointment of Trust special administrator) of the 2006 Act.

37.2.3 a copy of any information published under section 65D (appointment of Trust special administrator) of the 2006 Act.

37.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

37.2.5 a copy of any statement provided under section 65F (administrator's draft report) of the 2006 Act.

37.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (NHS England's decision), 65KB (Secretary of State's response to NHS England's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

37.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

37.2.8 a copy of any final report published under section 65I (administrator's final report).

37.2.9 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

37.2.10 a copy of any information published under section 65M (replacement of Trust special administrator) of the 2006 Act.

37.3 Any person who requests a copy of or extract from any of the above documents is to be provided with a copy or extract.

37.4 If the person requesting a copy is not a member of the Trust, the Trust may impose a reasonable charge for doing so.

38. Auditor

38.1 The Trust shall have an Auditor.

38.2 A person may only be appointed Auditor if he (or in the case of a firm each of its members) is a member of one or more of the bodies referred to in Paragraph 23(4) of Schedule 7 to the 2006 Act.

38.3 The Council of Governors shall appoint or remove the Auditor at a general meeting of the Council of Governors in accordance with paragraph 23 of Schedule 7 to the 2006 Act.

38.4 The Auditor shall carry out its duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by NHS England on standards, procedures and techniques to be adopted.

39. Audit Committee

39.1 The Trust shall establish a Committee of Group Non-Executive Directors (at least one of whom that has competence in accounting and/or auditing and recent and relevant financial experience) as an Audit Committee to perform such monitoring, reviewing and other functions as are appropriate.

39.2 The Group Chairman should not be a member of the Committee.

39.3 The Group Deputy Chairman and/or the Group Senior Independent Director shall not chair the Committee.

40. Accounts

40.1 The Trust must keep proper accounts and proper records in relation to the accounts.

40.2 NHS England may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

40.3 The accounts are to be audited by the Trust's Auditor.

40.4 The Trust shall prepare in respect of each financial year annual accounts in such form as NHS England may with the approval of the Secretary of State direct.

40.5 The functions of the Trust with respect to the preparation of the annual accounts shall be delegated to the Accounting Officer.

40.6 The Trust shall lay a copy of the annual accounts, and any report of the auditor on them, before parliament and once it has done so, send copies of those to NHS England.

40.7 Further provisions as to the accounts are set out at Annex7 (Further Provisions).

41. Annual Report, Forward Plans and Non-NHS Work

41.1 The Trust shall prepare an Annual Report and send it to NHS England.

41.1A Each Annual Report must, in particular, review the extent to which the Trust has exercised its functions:

41.1 A.1 in accordance with the plans published under:

41.1A.1.1 section 14Z52 of the 2006 Act;

41.1A.1.2 section 14Z56 of the 2006 Act

41.1A.2 consistently with NHS England's views set out in the latest statement published under section 13SA(1)

41.1B Each Annual Report shall provide:

41.1B.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of its public constituencies and the classes of the staff constituency is representative of those eligible for such membership;

41.1B.2 information on any occasions in the period to which the report relates on which the Council of Governors exercised its powers under paragraph 33.2 and such other procedures as the Trust has on pay;

41.1B.3 information on the remuneration of the directors and on the expenses of the governors and the directors; and

41.1B.4 any other information NHS England requires.

41.1C The Trust is to comply with any decision NHS England makes as to:

41.1C.1 the form of the report;

41.1C.2 when the report are to be sent to it;

41.1C.3 the periods to which the report relates.

41.2 The Trust shall give information as to its forward planning in respect of each financial year to NHS England.

41.3 The document containing the information with respect to forward planning (referred to above) shall be prepared by the Directors.

41.4 In preparing the document, the Directors shall have regard to the views of the Council of Governors.

41.5 Each forward plan must include information about:

41.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

41.5.2 the income it expects to receive from doing so.

41.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 41.5.1 the Council of Governors must:

41.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfillment by the Trust of its principal purpose or the performance of its other functions, and

41.6.2 notify the Directors of the Trust of its determination.

41.7 Where the Trust proposes to increase by 5% or more the proportion of its total income in any financial year attributable to activities other than the provision of goods and services for the purposes of the NHS in England may implement the proposal only if more than half of the members of the Council of Governors voting approve its implementation.

41.8 Further provisions as to Annual Reports is outlined in Annex 7 (Further Provisions).

42. Presentation of the Annual Accounts and Reports to the Governors and Members

42.1 The following documents are to be presented to the Council of Governors at a general meeting of the Council of Governors:

42.1.1 the annual accounts

42.1.2 any report of the auditor on them

42.1.3 the annual report.

42.2 The documents shall also be presented to the Members of the Trust at the Annual Members' Meeting by at least one member of the Board of Directors in attendance.

42.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of sub-paragraph 42.1 with the Annual Members' Meeting.

43. Instruments

43.1 The Trust shall have a seal.

43.2 The seal shall not be affixed except under the authority of the Board of Directors. Attestation by any two directors shall be deemed to constitute affixing the seal under the authority of the Board of Directors.

44. Amendment of the Constitution

44.1 The Trust may make amendments of its Constitution only if:

44.1.1 More than half of the members of the Council of Governors of the Trust voting approve the amendments, and

44.1.2 More than half of the members of the Board of Directors of the Trust voting approve the amendments.

44.2 Amendments made under paragraph 44.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the Constitution would, as a result of the amendment, not accord with schedule 7 of the 2006 Act.

44.3 Where an amendment is made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

44.3.1 At least one Governor must attend the next Annual Members' Meeting and present the amendment, and

44.3.2 The Trust must give the members an opportunity to vote on whether they approve the amendment.

If more than half of the members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

44.4 Amendments by the Trust of its Constitution are to be notified to NHS England. For the avoidance of doubt, NHS England's functions do not include a power or duty to determine whether or not the Constitution, as a result of the amendments, accords with Schedule 7 of the 2006 Act.

45. Mergers etc. and Significant Transactions

45.1 The Trust may only apply for a Statutory Transaction with the approval of more than half of the members of the Council of Governors.

45.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors of the Trust voting approve entering into the transaction.

45.3 'Significant Transaction' is defined as:

45.3.1 The acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 25% of the value of the Trust's gross assets before the acquisition; or

45.3.2 The disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 25% of the value of the Trust's gross assets before the disposition; or

45.3.3 A transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the

value of which is more that 25% of the value of the Trust's gross assets before the transaction.

45.4 For the purpose of this paragraph 45:

45.4.1 'Gross assets' means the total of fixed assets and current assets;

45.4.2 In assessing the value of any contingent liability for the purposes of sub-paragraph 45.3.3, the Directors:

45.4.2.1 must have regard to all circumstances that the Directors know, or ought to know, affect, or may affect, the value of the contingent liability; and

45.4.2.2 may rely on estimates of the contingent liability that are reasonable in the circumstances; and

45.4.2.3 may take account of the likelihood of the contingency occurring; and

45.4.3 A Statutory Transaction is not a Significant Transaction.

45.5 The views of the Council of Governors will be taken into account before the Trust enters into any proposed transaction which would exceed a threshold of 10% for any of the criteria set out in paragraph 45.3 above.

46. Indemnity

46.1 Governors and Directors who act honestly and in good faith and not recklessly will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their Council of Governors or Board of Directors functions. Any such liabilities will be liabilities of the Trust.

46.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust, the Council of Governors, the Board of Directors, and the Board Secretary.

47. Validity of Actions

No defect or deficiency in the appointment or composition of the members or the Council of Governors or the Board of Directors shall affect the validity of any decision or action taken by them.

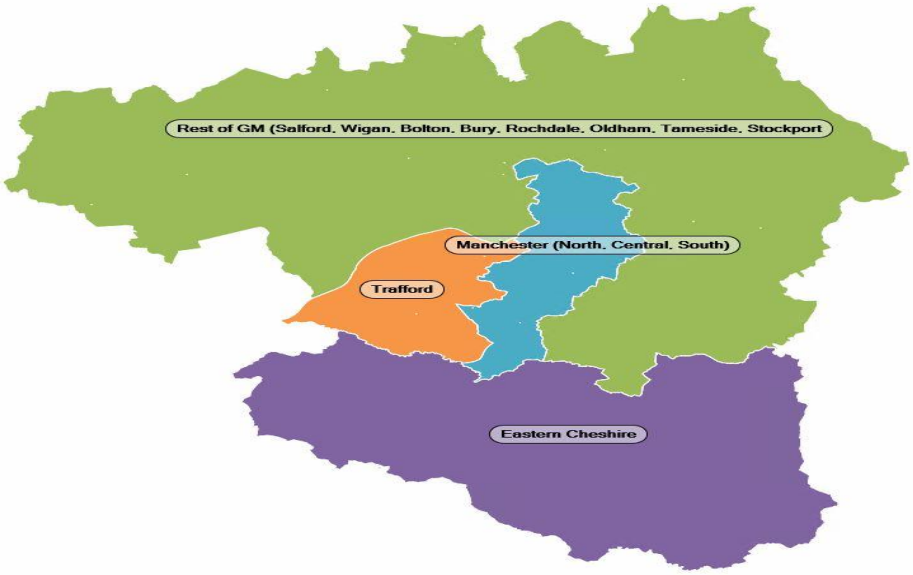
ANNEX 1

The Public Constituencies

(Paragraphs 7.1 and 7.3)

Name of Public Membership Constituency	Electoral wards within the following Local Authority boundaries	Minimum Number of Public Members
Manchester	Manchester City Council	4
Trafford	Trafford MBC	4
Eastern Cheshire	Cheshire East Council Electoral Wards as follows: Alderley Edge Bollington Broken Cross and Upton Chelford Disley Gawsworth Handforth High Legh Knutsford Macclesfield Central Macclesfield East Macclesfield Hurdsfield Macclesfield South Macclesfield Tytherington Macclesfield West and Ivy Mobberley Poynton East & Pott Shrigley Poynton West & Adlington Prestbury Sutton Wilmslow Dean Row Wilmslow East Wilmslow Lacey Green Wilmslow West & Chorley	4
Rest of Greater Manchester	Bolton MBC Bury MBC Oldham MBC Rochdale MBC Salford City Council Stockport MBC Tameside MBC Wigan MBC	4
Rest of England and Wales	All electoral areas in England and Wales not listed above	4

The map below illustrates the Public Member Constituencies for Manchester, Trafford, Eastern Cheshire and Rest of Greater Manchester areas. Areas that fall outside these Constituencies are captured in the Rest of England and Wales Constituency



ANNEX 2

The Staff Constituency

(Paragraphs 8.4 and 8.5)

Name of Staff Constituency	Minimum Number of Staff
Medical and Dental	4
Nursing and Midwifery	4
Other Clinical	4
Non-Clinical and Support	4

ANNEX 3

Composition of the Council of Governors

(Paragraphs 12.2 and 12.3)

1. The aggregate number of Public Governors is to be more than half of the total number of members of the Council of Governors.

2. The Trust, subject to the 2006 Act, shall seek to ensure that:

   2.1 the composition of the Council of Governors reflects the composition of the membership

   2.2 the level of representation of the Public Constituencies, the classes of the Staff Constituency and the appointing organisations strikes an appropriate balance having regard to their legitimate interest in the Trust's affairs;
   and to this end, the Council of Governors:

   2.3 shall at all times maintain a policy for the composition of the Council of Governors which takes account of the composition of the membership, the membership strategy, and shall from time to time and not less than every three years review the policy for the composition of the Council of Governors, and

   2.4 when appropriate shall propose amendments to this Constitution.

3. The Council of Governors, subject to the 2006 Act, shall seek to ensure that the interests of the members as a whole and the public and communities served by the Trust are appropriately represented;

4. The Council of Governors of the Trust is to comprise:

Public Governors	**17**
Manchester	7
Trafford	2
Eastern Cheshire	1
Greater Manchester	5
Rest of England and Wales	2

Staff Governors	**7**
Medical and Dental	1
Nursing and Midwifery	2
Other Clinical	2
Non-Clinical and Support	2

Appointed Governors	**8**
Local Authority (Manchester City Council and Trafford Council)	2
Manchester University	1
NHS Greater Manchester Integrated Care Board	1
Trust Volunteer	1
Trust Youth Forum	1
Manchester Council for Community Relations or Manchester BME Network	1
Umbrella third section organisation	1
Council of Governors Total	**32**

ANNEX 4

Additional Provisions – Council of Governors

Elected Governors

1. A member of the Public Constituency may not vote at an election for a Public Governor unless during the voting process they sign a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant area of a Public Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

2. A member of the Staff Constituency may not vote at an election for a Staff Governor unless during the voting process they sign a declaration in the form specified by the Secretary that they are qualified to vote as a member of the relevant class of the Staff Constituency. It is an offence to knowingly or recklessly make such a declaration which is false in a material particular.

Appointed Governors

3. The Appointed Governors are to be appointed by the partnership organisations, in accordance with a process agreed with the Secretary.

Tenure for Elected and Appointed Governors

4. A Governor shall normally hold office for a period of three years commencing immediately after the Annual Members' Meeting or other Members' Meeting (forum) at which his election or appointment is announced.

5. For the purposes of these provisions concerning terms of office for Governors, "year" means a period commencing immediately after the conclusion of the Annual Members' Meeting or other Members' Meeting at which their election or appointment was announced and ending at the conclusion of the next Annual Members' Meeting, but in any event shall not exceed a period of 12 calendar months.

6. A Governor may not stand again for re-election or re-appointment as a Governor until three years has elapsed since he resigned, or he completed the maximum three terms or nine consecutive years as a Governor.

6A A Governor may resign from office at any time during the term of office by giving notice in writing to the Trust Secretary save that if in the opinion of the Trust Secretary the Governor's conduct and tenure are or may become subject to review or investigation (investigation procedure set out in Annex 9) which may lead to his or her removal under paragraph 10 below, then any such notice of resignation will not be effective without the agreement of the Group Chairman or (if the Group Chairman is conflicted) the Group Deputy Chairman.

6B The Group Chairman or (if the Group Chairman is conflicted) the Group Deputy Chairman may suspend a Governor whose conduct and tenure are subject to review or investigation if in the opinion of the Group Chairman or the Group Deputy Chairman such review or investigation may lead to the Governor's removal under paragraph 10 below.

Appointment of Lead Governor of the Council of Governors

7. The Council of Governors shall elect one of the Governors to be Lead Governor of the Council of Governors.

7.1 Lead Governor elections will usually be held following the Annual Members' Meeting.

7.2 Candidates from all Governor constituencies (Public, Staff and Appointed) are eligible to stand for election as Lead Governor.

7.3 Governors must have served within their current term of office or previous term(s), if consecutive, a minimum of 12 months experience as a Governor of the Trust in order to be eligible to stand for election as the Lead Governor .

7.4 Results of Lead Governor elections shall be announced at the next general meeting of the Council of Governors.

7.5 The Lead Governor's term of office shall be for 12 months commencing immediately at the general meeting of the Council of Governors at which his election is announced. The Lead Governor shall serve a maximum of two terms of office unless in exceptional circumstances agreed by the Chairman of the Council of Governors.

7.6 The Lead Governor shall cease to hold office if he ceases to be a member of the Council of Governors.

7.7 The Secretary shall inform NHS England of the Lead Governor's name upon election.

7.8 Where a vacancy arises for the elected Lead Governor, the Council of Governors shall be at liberty either:

7.8.1 to call an election within three months to elect a Lead Governor for the remainder of the previous Lead Governor's term of office; or

7.8.2 to invite the next highest polling candidate at the most recent election for Lead Governor, who is willing to take office, to undertake the role of Lead Governor until the next annual election, at which time the role will fall vacant; or

7.8.3 to leave the seat vacant until the next Lead Governor elections are held and nominate a Governor to act as Acting Lead Governor until an election takes place

Further Provisions as to Eligibility to be a Governor

8. A person may not become a Governor of the Trust, and if already holding such office will immediately cease to do so, if:

8.1 they are a Director of the Trust or a Governor or Director of an NHS body (unless they are appointed by an appointing organisation which is an NHS body);

8.2 they are the spouse, partner, parent or child of a member of the Board of Directors of the Trust;

8.3 they are a member of a local authority's Scrutiny Committee covering health matters;

8.4 they have been previously removed as a Governor pursuant to paragraph 9 of this Annex 4 or they are otherwise a person whose tenure as a Governor of another Foundation Trust has been terminated for cause

8.5 being a member of the Public Constituency, they refuse to sign a declaration in the form specified by the Secretary of particulars of their qualification to vote as a member of the Trust, and that they are not prevented from being a member of the Council of Governors;

8.6 they are subject to an order under the Sexual Offences Act 2003;

8.7 they have, within the preceding two years been dismissed, otherwise than by reason of redundancy, from any paid employment with an NHS body;

8.8 they are a person whose tenure of office as the Chairman or as a member or director of an NHS body has been terminated on the grounds that their appointment is not in the interests of the health service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest;

8.9 they are a person who is not a fit and proper person as defined by regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and / or conditions of the Trust's License.

8.10 they are a person who refuses to undertake a Disclosure & Barring Service (DBS) check and/or other fit and proper person checks including insolvency, bankruptcy and disqualified directors' registrations alongside health questionnaire/checks;

8.10.1 a Governor will be disqualified if on the basis of disclosure(s) (convictions/cautions) obtained through a DBS and or/other fit and proper person checks, he is not considered suitable by the Trust:

8.10.1.1 such a person is such that it would be inappropriate for him to become or as a Governor or

8.10.1.2 would adversely affect public confidence in the Trust or otherwise bring the Trust into disrepute.

8.11 they are a person who does not adhere to the Governors' Code of Conduct.

8.12 they are currently or have previously been a Governor of an NHS Foundation Trust other than the Trust, unless the Group Chairman decides that they may become or continue as a Governor.

8.13 being a member of the Staff Constituency they have a current and unexpired written warning which has been imposed following disciplinary action by the Trust arising out of their employment with the Trust. If a Staff Governor is suspended from duties for any reason they will also be suspended from their role as a Staff Governor for the duration of their suspension. Whilst a Staff Governor is under suspension, the Staff Governor cannot attend meetings of the Council of Governors as a member of the Council of Governors, but missing any meetings of the Council of Governors will not count as failure to attend for the purposes of paragraph 9.2 of this Annex 4. Spent disciplinary warnings will not preclude eligibility to be a Governor;

8.14 they are a vexatious complainant within the context of the following meaning

that who as an individual

a) has threatened, harassed, harmed or abused staff, patients and/or visitors of the Trust; or

b) has been a vexatious complainant. For the purposes of this paragraph a vexatious complainant is an individual who is found by the Trust (applying the relevant Trust policy) to have abused or used inappropriately the Trust's or a predecessor Trust's complaints procedure,

shall be refused membership of the Trust or where an existing member shall have their membership of the Trust withdrawn.

9. A person holding office as a Governor shall immediately cease to do so if:

9.1 they resign by notice in writing to the Secretary;

9.2 they fail to attend three consecutive meetings of the Council of Governors, unless the other Governors are satisfied that:

9.2.1 the absences were due to reasonable causes; and

9.2.2 they will be able to start attending meetings of the Council of Governors again within such a period as the other Governors consider reasonable;

9.3 they have refused without reasonable cause to undertake any training which the Council of Governors requires all Governors to undertake;

9.4 they have failed to sign and deliver to the Secretary a statement in the form required by the Secretary confirming acceptance of the Governors' Code of Conduct;

9.5 they are removed from the Council of Governors under paragraph 10 below or any other provisions set out in this Constitution.

10. A Governor may be removed from the Council of Governors by a resolution approved by not less than three-quarters of the remaining Governors present and voting on the grounds that:

10.1 they have committed a serious breach of the Governors' Code of Conduct; or

10.2 they have acted in a manner detrimental to the interests of the Trust; and

10.3 the Council of Governors consider that it is not in the best interests of the Trust for them to continue as a Governor.

Vacancies amongst Governors

11. Where a vacancy arises on the Council of Governors for any reason other than expiry of term of office, the following provisions will apply.

12. Where the vacancy arises amongst the appointed Governors, the Secretary shall request that the appointing organisation appoints a replacement or to leave the seat vacant until the next annual round of Governor appointments (nominations) are held.

13. Where the vacancy arises amongst the Elected Governors, the Council of Governors shall be at liberty either:

13.1 to call an election within three months to fill the seat for the remainder of the previous Governor's term of office; or

13.2 to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office,; or

13.3 to leave the seat vacant until the next elections are held.

Further Provisions on the Relationship between the Council of Governors and the Board of Directors

14. The Council will agree with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.

15. If the Council does not accept the Audit Committee's recommendation, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council had taken a different position.

ANNEX 5

Standing Orders for the Practice and Procedure of the Council of Governors

1 INTERPRETATION

In these Standing Orders:

(a) unless the context otherwise requires, the following expressions have the following meanings:

"Meeting"	means a duly convened meeting of the Council of Governors;
"Motion"	means a formal proposition (either with or without notice pursuant to Standing Orders 10 and 11) to be discussed and voted on during the course of a Meeting about a matter for which the Council of Governors has responsibility;
"Question on Notice"	means a question from a Governor or Governors (notice of which has been given pursuant to Standing Order 7) about a matter for which the Council of Governors has responsibility;

(b) other terms defined in the Constitution shall have the same meaning in these Standing Orders.

2 THESE STANDING ORDERS

These Standing Orders for the Practice and Procedures of the Council of Governors are the standing orders referred to in paragraph 20 of the Constitution. They may be amended in accordance with the procedure set out in Standing Order 20 below. If there is any conflict between these Standing Orders and the Constitution, the Constitution shall prevail.

3 MEETINGS

Meetings of the Council of Governors shall be open to members of the public unless the presiding Chair decides otherwise in relation to all or part of the meeting for reasons of commercial confidentiality or on other proper grounds.

Meetings of the Council of Governors shall be held at regular intervals at such times and places as the Group Chairman may determine from time to time. The Secretary will publish the dates, times and locations of meetings of the Council of Governors for the year 6 months in advance. Other, or emergency, meetings of the Council of Governors may be called in accordance with the Constitution.

4 AGENDAS AND PAPERS

An agenda, copies of any Questions on Notice and/or motions on notice to be considered at the relevant Meeting and any supporting papers shall be sent to each Governor so as to arrive with each Governor normally no later than 7 days in advance of each Meeting. Minutes of the previous Meeting will be circulated with these papers for approval and this will be a specific agenda item.

5 REPORTS FROM THE GROUP EXECUTIVE DIRECTORS

At any Meeting a Governor may ask any question through the Group Chairman without notice on any report by a Group Executive Director, or other officer of the Trust, after that report has been received by or while such report is under consideration by the Council of Governors at the Meeting. Unless the Group Chairman decides otherwise no statements will be made other than those which are strictly necessary to define any question posed and in any event no statements will be allowed to last longer than 3 minutes each. A Governor who has put such a question may also put one supplementary question if the supplementary question arises directly out of the reply given to the initial question. The Group Chairman may, in its absolute discretion, reject any question from any Governor if in the opinion of the Group Chairman the question is substantially the same and relates to the same subject matter as a question which has already been put to that Meeting or a previous Meeting.

6 QUESTIONS ON NOTICE AT MEETINGS

Subject to the provisions of Standing Order 7, a Governor may ask a Question on Notice of:

(a) the Group Chairman;

(b) another Governor;

(c) a Group Executive Director of the Trust;

(d) the chairman of any sub-group of the Council of Governors.

7 NOTICE OF QUESTIONS

Notice of a Question on Notice must be given in writing to the Secretary at least 14 days prior to the relevant Meeting. For the purposes of this Standing Order 7, receipt of any such Questions on Notice via electronic means is acceptable.

8 RESPONSE TO A QUESTION ON NOTICE

An answer to a Question on Notice may take the form of:

(a) a direct oral answer at the relevant Meeting (which may, where the desired information is in a publication of the Trust or other published work, take the form of a reference to that publication);

(b) where the reply cannot conveniently be given orally at the relevant Meeting, a written answer which will be circulated as soon as reasonably practicable to the questioner and to the other Governors or with the agenda for the next Meeting; or

(c) a brief oral answer at the relevant Meeting supplemented by a written answer circulated as soon as reasonably practicable to the questioner and to the other Governors and/or information will be provided as an agenda item for the next Meeting.

9 SUPPLEMENTARY QUESTIONS IN RESPECT OF A QUESTION ON NOTICE

Supplementary questions for the purpose of clarification of a reply to a Question on Notice may be asked at the absolute discretion of the Group Chairman.

10 MOTIONS ON NOTICE

(a) Notice

Subject to Standing Order 11, a motion may only be submitted by Governors and must be received by the Secretary in writing at least 14 days prior to the Meeting at which it is proposed to be considered, together with any relevant supporting papers. Except for motions which can be moved without notice under Standing Order 11, the notice of every motion must be signed or transmitted by at least two Governors. For the purposes of this Standing Order 10, receipt of any such motions via electronic means is acceptable. All motions received by the Secretary will be acknowledged by the Secretary in writing to the Governors who have signed or transmitted the same.

(b) Scope

Motions may only be about matters for which the Council of Governors has a responsibility.

11 MOTIONS WITHOUT NOTICE

The following motions may be moved at any Meeting without notice:

(a) in relation to the accuracy of the minutes of the previous Meeting;

(b) to change the order of business in the agenda for the Meeting;

(c) to refer a matter discussed at a Meeting to an appropriate body or individual;

(d) to appoint a group arising from an item on the agenda for the Meeting;

(e) to receive reports or adopt recommendations made by the Board of Directors;

(f) to withdraw a motion;

(g) to amend a motion;

(h) to proceed to the next business on the agenda;

(i) that the question be now put;

(j) to adjourn a debate;

(k) to adjourn a Meeting;

(l) to suspend a particular Standing Order contained within these Standing Orders (provided that any Standing Order may only be suspended if at least one half of the aggregate number of Governors are present at the Meeting in question and provided also that the Standing Order in question may only be suspended for the duration of the Meeting in question);

(m) to exclude the public and press from the Meeting in question (the motion shall be "To exclude the press and public from the remainder of the Meeting, owing to the confidential nature of the business to be transacted.");

(n) to not hear further from a Governor, or to exclude them from the Meeting in question (if a Governor persistently disregards the ruling of the Group Chairman or behaves improperly or offensively or deliberately obstructs business, the Group Chairman, in its absolute discretion, may move that the Governor in question be not heard further at the Meeting in question. If seconded, the motion will be voted on without discussion. If the Governor continues to behave improperly after such a motion is carried, the Group Chairman may move that either the Governor leaves the meeting room or that the Meeting in question is adjourned for a specified period. If seconded, the motion will be voted on without discussion);

(o) to give the consent of the Council of Governors to any matter where its consent is required pursuant to the Constitution.

12 URGENT MOTIONS OR QUESTIONS

Urgent motions or questions may only be submitted by a Governor and must be received by the Secretary in writing before the commencement of the Meeting in question. The Group Chairman shall decide whether the motion or question in question should be tabled.

13 SPEAKING

This Standing Order applies to all forms of speech/debate by Governors or members of the Trust and the public in relation to the motion or question under discussion at a Meeting.

(a) Content and Length of Speeches

Any approval to speak must be given by the Group Chairman. Speeches must be directed to the matter, motion or question under discussion or to a point of order. Unless in the opinion of the Group Chairman it would not be desirable or appropriate to time limit speeches on any topic to be discussed having regard to its nature complexity or importance, no proposal, speech, nor any reply, may exceed three minutes. In the interests of time the Group Chairman may, in its absolute discretion, limit the number replies questions or speeches which are heard at any one Meeting.

(b) When a person may speak again

A person who has already spoken on a matter at a Meeting may not speak again at that Meeting in respect of the same matter, except:

(i) in exercise of a right of reply;

(ii) on a point of order.

(c) Identification

All speakers must state their name and role before starting to speak to ensure the accuracy of the minutes.

14 VOTING

All questions put to the vote shall, at the discretion of the Group Chairman, be decided by a show of hands, or if meeting is being held virtually (video or teleconferencing) via the associated electronic or verbal communication channels. A paper ballot may be used if a majority of the Governors present so request.

15 ATTENDANCE

Governors who are unable to attend a Meeting shall notify the Secretary in writing in advance of the Meeting in question so that their apologies may be submitted.

16 QUORUM

The quorum for a Meeting will be as set out in paragraph 18.3 of this Annex 5 to the Constitution.

17 CHAIRMAN

The arrangements for presiding at or chairing meetings of the Council of Governors are set out in the Constitution.

18 Further Provisions as to Meetings of Governors

18.1. The Council of Governors is to meet at least four times in each financial year. Save in the case of emergencies or the need to conduct urgent business, the Secretary shall give at least seven days written notice of the date and place of every meeting of the Council of Governors together with an agenda and any supporting papers to all Governors. Notice will also be published on the Trust's website.

18.2. Meetings of the Council of Governors may be called by the Secretary, or by the Group Chairman, or by ten Governors (including at least two Elected Governors and two Appointed Governors) who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Governors as soon as possible after receipt of such a request. The Secretary shall call a meeting on at least seven but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Group Chairman or ten Governors, whichever is the case, shall call such a meeting.

18.3. Eleven Governors including not less than four Public Governors, not less than one Staff Governor and not less than one Appointed Governors shall form a quorum.

18.4. The Council of Governors may invite the Group Chief Executive or any other member or members of the Board of Directors, or a representative of the auditor or other advisors to attend a meeting of the Council of Governors.

18.5 The Council of Governors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting.

18.6 Subject to the following provisions of this paragraph, questions arising at a meeting of the Council of Governors shall be decided by a majority of votes. No resolution of the Council of Governors shall be passed if it is opposed by all of the Public Governors present.

18.7 The Council of Governors may not delegate any of its powers to a group, committee or sub-committee, but it may appoint committees consisting of its members, Directors, and other persons to assist the Council of Governors in carrying out its functions. The Council of Governors may, through the Secretary, request that advisors assist them or any committee they appoint in carrying out its duties.

18.8 All decisions taken in good faith at a meeting of the Council of Governors or of any group or committee shall be valid even if it is discovered subsequently that there was a defect in the calling of the meeting, or the appointment of the Governors attending the meeting.

Declaration

18.9 An Elected Governor may not vote at a meeting of the Council of Governors unless, before attending the meeting, they have made a declaration in the form specified by the Secretary of the particulars of their qualification to vote as a member of the Trust and that they are not prevented from being a Governor. An Elected Governor shall be deemed to have confirmed the declaration upon attending any subsequent meeting of the Council of Governors, and every agenda for meetings of the Council of Governors will draw this to the attention of Elected Governors

19 FURTHER PROVISIONS IN RESPECT OF THE COUNCIL OF GOVERNORS CONFLICTS OF INTEREST OF GOVERNORS

19.1 A material interest is:

a. any directorship of a company;
b. any interest or position in any firm, company, business, or organisation (including any charitable or voluntary organisation) which has or is likely to have a trading or commercial relationship with the Trust;
c. any interest in an organisation providing health and social care services to the National Health Service;
d. a position of authority in a charity or voluntary organisation in the field of health and social care;
e. any connection with any organisation, entity or company considering entering into a financial arrangement with the Trust including but not limited to lenders or banks.

20 DECLARATION OF INTERESTS

20.1 Any Governor who has an interest in a matter to be considered by the Council of Governors (whether because the matter involves a firm, company, business, or organisation [including any charitable or voluntary organisation] in which the Governor or his spouse or partner has a material interest or otherwise) shall declare such interest to the Council of Governors and:

a. shall withdraw from the meeting and play no part in the relevant discussion or decision; and

b. shall not vote on the issue (and if by inadvertence they do remain and vote, their vote shall not be counted).

20.2 Details of any such interest shall be recorded in the register of interests of Governors.

20.3 Any Governor who fails to disclose any interest or material interests required to be disclosed under these provisions must permanently vacate their office if required to do so by a majority of the remaining Governors.

21 AMENDMENTS TO STANDING ORDERS

These Standing Orders may only be amended at a Meeting. A motion to change the Standing Orders must be signed by five Governors and submitted to the Secretary in writing at least 21 days before the Meeting at which the motion is intended to be proposed.

22 DISPUTES BETWEEN THE COUNCIL OF GOVERNORS AND THE BOARD OF DIRECTORS

Dispute Resolution Procedure:

1 The Council of Governors adopts a policy to proactively engage with the Board of Directors in those circumstances when they have concerns. The Council of Governors is encouraged to ensure its interaction and relationship with the Board of Directors is appropriate and effective.

2 The Council of Governors elects a Lead Governor who is the first point of contact when Governors wish to seek advice and/or raise issues and who acts as the Council of Governors lead representative to the Group Chairman on Governor matters.

3 In the event of a dispute arising between the Council of Governors and the Board of Directors, the Group Chairman (or Group Senior Independent Director or Group Deputy Chairman if the dispute involves the Group Chairman) will endeavour to resolve the dispute informally, through discussions with the Council of Governors.

4 If Governors have concerns and when approaches through normal channels (Lead Governor and/or Group Chairman and/or Group Deputy Chairman) have failed to resolve or for which such approaches are inappropriate, the Group Senior Independent Director (SID) acts as the point of contact for Governors with the Board of Directors.

5 The Group SID also acts as the point of contact for Governors with the Board of Directors during the Group Chairman's annual performance appraisal process (includes remuneration and other allowances).

The Council of Governors should only exercise its power to remove the Group Chairman, or any other Group Non-Executive Director, after exhausting all means of engagement with the Board.

ANNEX 6

Standing Orders for the Practice and Procedure of the Board of Directors

	Record of Attendance
	Quorum
	Meetings – Electronic Communication
5	Arrangements for the Exercise of Functions by Delegation
	Emergency Powers
	Delegation to Committees
	Delegation to Officers
	Non-compliance with Standing Orders
6	Committees
7	Confidentiality
8	Declaration of Interests and Register of Interests
	Declaration of Interests
	Register of Interests
	Register of Gifts and Hospitality
9	Disability of Directors in Proceedings on Account of Pecuniary Interest
10	Standards of Business Conduct Policy
	Policy
	Interests of Directors, Officers, all staff, Consultants, Contractors and Governors
	Legislation Governing Public Procurement
	Guidance on Procurement and Commissioning
	Formal Competitive Tendering
	Contracts
	Personal and Agency or Temporary Staff Contracts
	Legally Binding Contracts for the Provisions of Healthcare
	Cancellation of Contracts
	Determination of Contracts for Failure to Deliver Goods or Material
11	Disposals
12	In-House Services
13	Custody of Seal and Sealing of Documents
	Requirements to seal
	Custody of seal
	Sealing Document
	Register of Sealing
14	Signature of Documents
15	Miscellaneous
	Standing Orders to be given to Board Members and Officers
	Documents having the standing of Standing Orders
	Review of Standing Orders
	Dispute Resolution

1. Introduction

Statutory Framework

The Manchester University NHS Foundation Trust (the Trust) is a public benefit corporation which came into existence on 1st October 2017 following the grant of an application by Monitor (now NHS England) pursuant to section 56 of the National Health Service Act 2006.

The functions of the Trust are conferred by the National Health Service Act 2006 and the Trust will exercise its functions in accordance with the terms of its provider license (no: **130164**) and all relevant legislation and guidance.

- The principal places of business of the Trust are:
- Manchester Royal Infirmary
- Manchester Royal Eye Hospital
- Royal Manchester Children's Hospital
- Saint Mary's Hospital
- Trafford General Hospital
- University Dental Hospital of Manchester
- Wythenshawe Hospital
- Altrincham Hospital
- Withington Hospital
- North Manchester General Hospital
- Manchester and Trafford Local Care Organisations

The Constitution requires the Board to adopt Standing Orders for the regulation of its proceedings and business. Nothing in these standing orders shall override the Trust's Constitution, the National Health Service Act 2006,the Health and Social Care Act 2012 or the Health and Care Act 2022.

As a public benefit corporation, the Trust has specified powers to contract in its own name and to act as a corporate trustee. In the latter role it is accountable to the Charity Commission for those funds deemed to be charitable. The Trust also has a common law duty as a bailee for patients' property on behalf of patients.

2. Purpose

2.1 Delegation of Power

All the powers of the Trust are exercisable by the Board of Directors. The Constitution may provide for any of those powers to be delegated to a committee of Directors or to a Group Executive Director. Delegated powers are covered in a separate Scheme of Delegation. The Scheme of Delegation has effect as if incorporated into the Standing Orders.

2.2 Interpretation

2.2.1 Save as otherwise permitted by law, at any meeting the Group Chairman of the Trust shall be the final authority on the interpretation of Standing Orders (on which he/she should be advised by the Group Chief Executive and/or Secretary to the Board of Directors).

2.2.2 Words importing the masculine gender only shall include the feminine gender and words importing the singular shall import the plural and vice-versa.

2.2.3 Any expression to which a meaning is given in the Constitution, the 2006 Act, the 2012 Act or the 2022 Act shall have the same meaning in this interpretation and in addition:

"Budget" is a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

‘**’Committee of the Board of Directors’’** is a committee formed by the Board with specific Terms of Reference, Chair and membership.

"Contracting and procuring" is the systems for obtaining the supply of goods, materials, manufactured items, services, building and engineering services, works of construction and maintenance and for disposal of surplus and obsolete assets.

"Group Executive Director of Finance" is the Group Chief Financial Officer of the Trust who will ensure compliance with Standing Financial Instructions.

‘’Motion’’ is a formal proposition to be discussed and voted on during the course of a meeting.

“NHS Standard Contract” the NHS standard contract mandated by NHS England for use by commissioners for all contracts for healthcare services other than primary care.

“NHS Standard Terms and Conditions” the NHS terms and conditions for procuring goods and services published by NHS England.

“Nominated Officer” is an officer charged with the responsibility for discharging specific tasks within Standing Order in line with the 2006 Act.

"Officer" is an employee of the Trust or any person holding a paid appointment of office with the Trust.

“Regulators” means NHS England, the Care Quality Commission and any other public authority which regulates NHS Foundation Trusts;

“Remuneration Committee” is a Committee of the Board of Directors consisting of the Group Non-Executive Directors which determines the remuneration and allowances for the Group Chief Executive and Group Executive Directors.

"SFIs" means Standing Financial Instructions.

"SOs" means Standing Orders.

“Trust Hospital” is all or any hospital or other patient care facilities administered by the trust from time to time and designated by the Trust as falling within this definition.

3. BOARD OF DIRECTORS

3.1.1 All business shall be conducted in the name of the Trust.

3.1.2 All the powers of the Trust are exercisable by the Board of Directors, a committee of the Board of Directors or a Group Executive Director.

3.1.3 The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These powers and decisions are set out in the Scheme of Decisions and Scheme of Delegation and have effect as if incorporated into the Standing Orders.

3.1.4 The Board of Directors will function as a unitary Board. The Board is collectively responsible for discharging the powers and for the performance of the Trust. Group Executive Directors and Group Non-Executive Directors will have joint responsibility for every decision of the Board regardless of their individual skills or status.

3.2 Composition of the Board of Directors

3.2.1 In accordance with paragraph 23 of the Trust's Constitution the composition of the Board of Directors shall be:

3.2.1.1 a Non-Executive Director Group Chairman;
3.2.1.2 a minimum of five Group Non-Executive Directors;
3.2.1.3 a minimum of five Group Executive Directors:

- One of the Group Executive Directors shall be the Group Chief Executive.
- The Group Chief Executive shall be the Accounting Officer.
- One of the Group Executive Directors shall be the Group Executive Director of Finance (Group Chief Finance Officer).
- One of the Group Executive Directors is to be a registered medical practitioner, or, a registered dentist (within the meaning of the Dentists Act 1984).
- One of the Group Executive Directors is to be a registered nurse, or, a registered midwife.

3.2.2 The number of Group Directors may be increased provided always that at least half of the Board, excluding the Group Chairman, comprises of Group Non-Executive Directors.

3.2.3 The Trust Secretary (or nominated deputy) will be in attendance at all meetings of the Board.

3.3 Appointment and Removal of the Group Chairman and Group Non-Executive Directors

3.3.1 In accordance with paragraph 26 of the Constitution and guidance issued by NHS England, the Group Chairman and Group Non-Executive Directors are appointed

and removed by the Council of Governors at a general meeting of the Council of Governors.

3.3.2 The Group Chairman and Group Non-Executive Directors shall be appointed for a term of office of up to three years.

3.3.3 The Group Chairman and Group Non-Executive Directors may be appointed to serve a further term of up to three years (depending on satisfactory performance) and subject to the provisions of the 2006 Act in respect of removal of a Director.

3.3.4 The Group Chairman and Group Non-Executive Directors may, in exceptional circumstances, serve longer than six years subject to rigorous review/annual re-appointment and subject to external competition if recommended by the Board. Re-appointments are to be approved by the Council of Governors and in circumstances that term extends beyond six years, are to also be agreed with NHSE. In establishing that the Group Non-Executive Director continues to be independent, the Group Chairman and Group Senior Independent Director (Appraisal Facilitators) will take account of NHS England's guidance and conduct an evidence-based evaluation.

3.3.5 Any re-appointment after the second term of office (irrespective of tenure duration), for the Group Chairman and Group Non-Executive Directors, shall be subject to a performance evaluation carried out in accordance with procedures approved by the Council of Governors to ensure that those individuals continue to be effective, demonstrate commitment to the role and demonstrate independence. Unless agreed by NHSE, the Group Chairman or Group Non-Executive Directors should not remain in post beyond nine years from the date of their first appointment.

3.4 Appointment and Powers of Group Deputy Chairman

3.4.1 The Nominations Committee shall, following consultation with the Council of Governors, appoint one of the Group Non-Executive Directors as Group Deputy Chairman in accordance with paragraph 27.1 of the Constitution and, in similar manner, shall remove any person appointed from that position and appoint another Group Non-Executive Director in his place.

3.4.2 Before a resolution for any such appointment is passed, the Board may decide which of the Group Non-Executive Directors it recommends for that appointment; the Group Chairman shall advise the Nominations Committee and Council of Governors of the recommendation from the Board which will not be binding upon the Committee or Council but will be presented to the Council at its meeting before it comes to a decision.

3.4.3 In the absence of the Group Chairman, the Group Deputy Chairman shall be acting Group Chairman of the Trust.

3.4.4 Any Group Non-Executive Director may at any time resign from the office of Group Deputy Chairman by giving notice in writing to the Group Chairman. The Nominations Committee in consultation with the Council of Governors upon the recommendation of the Board may then appoint another Group Deputy Chairman in accordance with paragraph 27.1 of the Constitution.

3.4.5 Where the Group Chairman of the Trust has died or has ceased to hold office, or where he/she has been unable to perform his/her duties as Group Chairman owing to illness or any other cause, the Group Deputy Chairman shall act as Group Chairman until a new Group Chairman is appointed or the existing Group Chairman resumes his/her duties, as the case may be; and references to the Group Chairman in these Standing Orders shall, so long as there is no Group Chairman able to perform his/her duties, be taken to include references to the Group Deputy Chairman.

3.5 Appointment and Role of the Group Senior Independent Director

3.5.1 The Board of Directors shall, following consultation with the Council of Governors, appoint one of the Group Non-Executive Directors as a Group Senior Independent Director in accordance with paragraph 27.2 of the Constitution, for such a period not exceeding the remainder of the individual's term of office as a Group Non-Executive Director. The Group Senior Independent Director to act in accordance with NHS England's Code of Governance for NHS Provider Trusts (as may be amended and replaced from time to time); and the Trust's Standing Orders.

3.5.2 The Group Senior Independent Director (SID) is a role that is undertaken by one of the Trust's Independent Group Non-Executive Directors. The Group SID should be available to all stakeholders, particularly Governors and members, should they have concerns which they feel unable to resolve via normal channels, such as through contact with the Group Chairman or Group Chief Executive, or in circumstances in which such contact would be inappropriate.

3.5.3 The Group Senior Independent Director shall meet with the Group Chairman at least annually to evaluate his/her performance, as part of a process, which should be agreed with the Council of Governors and be in keeping with NHSE's guidance, for appraising the Group Chairman and on such occasions as are deemed appropriate.

3.6 **Terms of Office of the Group Chairman and Group Non-Executive Directors** - The Group Chairman and Group Non-Executive Directors shall be appointed with terms and conditions of office as decided by the Council of Governors at a general meeting taking account of NHS England governance guidance.

3.7 Appointment and Removal of the Group Chief Executive

3.7.1 In accordance with the Trust's Constitution paragraph 28, the Group Non-Executive Directors shall appoint or remove the Group Chief Executive.

3.7.2 The appointment of the Group Chief Executive requires the approval of the Council of Governors in accordance with paragraph 28.2 of the Trust's Constitution.

3.8 Appointment and Removal of Group Executive Directors

In accordance with the Constitution, paragraph 28.3, all Group Executive Directors (excluding the Group Chief Executive) are to be appointed (and removed) by a committee consisting of the Group Chairman, the Group Chief Executive and the other Group Non-Executive Directors.

3.9 Joint Directors

3.9.1 Where more than one person is appointed jointly to a post in the Trust which qualifies the holder for group executive directorship or in relation to which a Group Executive

Director is to be appointed, those persons shall count for the purpose of SO4. (composition of Board) as one person (save that the Group Executive positions of registered Medical Practitioner or registered Dental and registered Nurse or registered Midwife cannot be shared between the two professions).

3.9.2 Where such an arrangement is in force, both individuals shall be able to attend a meeting of the Board provided that at any meeting of the Board they may only count as one individual for the purposes of the quorum and may only exercise one vote between them.

3.9.3 Where the two individuals disagree as to how to vote at a Board meeting, then no vote shall be cast. If only one individual attends the meeting they can cast the vote on behalf of both.

3.9.4 The presence of either or both persons shall count as the presence of one person for the purposes of quorum.

3.10 **Trust Secretary**

The Group Chairman and Group Chief Executive shall appoint a Trust Secretary to act independently of the Board, to provide advice on corporate governance issues to the Group Chairman and Board, and to monitor the Trust's compliance with its regulatory framework, the Trust's Constitution and SOs.

3.11 **Role of Group Chief Executive**

3.11.1 The Group Chief Executive is responsible for implementing the decisions of the Board in the running of the Trust's business.

3.11.2 The Group Chief Executive reports to the Group Chairman of the Board.

3.11.3 The Group Chief Executive is the Accounting Officer and shall be responsible for ensuring the discharge of obligations under all relevant financial directions and guidance issued by NHS England or any other relevant body.

3.12 **Role of Group Chief Finance Officer**

3.12.1 The Group Chief Finance Officer shall be responsible for the provision of financial advice to the Trust and to its Group Directors and for the supervision of financial control and accounting systems.

3.12.2 The individual shall be responsible, along with the Group Chief Executive, to ensure the discharge of obligations under all relevant financial requirements, conditions or notices issued by any Regulators or other relevant body.

3.13 **Role of Group Executive Directors**

Group Executive Directors shall exercise their authority within these SOs, SFIs and SoRD.

3.14 **Role of the Group Chairman**

The Group Chairman shall be responsible for the leadership of the Board (and Council of Governors) and chair all Board (and Council of Governor) meetings when present.

3.14.1 The Group Chairman must ensure effectiveness in all aspects of the Board's role and lead on setting the agenda for meetings and ensure that adequate time is available for discussion of agenda items and strategic issues.

3.14.2 The Group Chairman is responsible for ensuring that the Board and Council of Governors work effectively together.

3.15 **Role of Group Non-Executive Directors**

The Group Non-Executive Directors shall not be granted nor shall they seek to exercise any individual executive powers on behalf of the Trust. They may, however, exercise collective authority when acting as members of or when chairing a Committee of the Trust which has delegated powers.

3.16 **The Board as a Trustee**

3.16.1 All funds received in trust shall be held in the name of the Trust as corporate trustee.

3.16.2 In relation to funds held in trust, powers exercised by the Board of Directors as corporate trustee shall be exercised separately and distinctly from those powers exercised as the Trust.

3.16.3 The Trust has the functions conferred on it by the 2006 Act. Directors acting on behalf of the Trust as a corporate trustee are acting as quasi-trustees. Accountability for charitable funds held on trust is to the Charity Commission and to the Secretary of State for Health. Accountability for non-charitable funds held on trust is only to NHS England.

3.17 **Relationship between the Board of Directors and Council of Governors**

3.17.1 The Council of Governors has a statutory duty to hold the Group Non-Executive Directors individually and collectively to account for the performance of the Board. This includes ensuring the Board acts so that the Trust does not breach the conditions of its License. It remains the responsibility of the Board to design and implement agreed priorities, objectives and the overall strategy of the Trust. The Council of Governors is responsible for representing the interests of the Trust's members and the public at large, and staff in the governance of the Trust. Governors must act in the best interests of the Trust and should adhere to its values and Governors' Code of Conduct. Governors are responsible for regularly feeding back information about the Trust, its vision and its performance to members, the public at large, and the stakeholder organisations that either elected or appointed them. The Trust should ensure that Governors have appropriate support to help them to discharge this duty.

3.17.2 The Board is to present to the Council of Governors, at a general meeting, the annual accounts, any report of the auditor on them, and the annual report.

3.17.3 The annual report should describe the process followed by the Council of Governors in relation to the appointments of the Group Chairman and Group Non-Executive Directors.

3.17.4 The Council of Governors will agree with the Audit Committee the criteria for appointing, re-appointing and removing External Auditors.

3.17.5 If the Council of Governors does not accept the Audit Committee's recommendation, the Board should include in the annual report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors had taken a different position.

4. MEETINGS OF THE BOARD OF DIRECTORS

4.1 Admission of the Public and Press

Meetings of the Board of Directors shall be open to members of the public and press in accordance with paragraph 30.1 of the Constitution.

4.1.1 Members of the public and the press may be excluded from a meeting for special reasons. Special reasons include for reasons of commercial confidentiality. The Board will resolve that:
'*In accordance with paragraph 30.1 of the Constitution and paragraph 18E of Schedule 7 of the 2006 Act, the Board of Directors resolves that there are special reasons to exclude members of the public from this meeting having regard to commercial sensitivity and/or confidentiality and/or personal information and/or legal professional privilege in relation to the business to be discussed*'.

4.1.2 Nothing within these SOs shall require the Board to allow members of the public or representatives of the press to record proceedings in any manner whatsoever, other than writing, or to make any oral report of proceedings as they take place, without prior agreement of the Board.

4.1.3 Matters discussed at a meeting following the exclusion of Governors. the public and representatives of the media shall be confidential to the Board and shall not be disclosed by any person attending the meeting without the consent of the Group Chairman of the meeting.

4.2 Calling Meetings

Ordinary meetings of the Board of Directors shall be held at such times and places as the Board of Directors may determine, with a minimum number of five meetings held each year.

4.2.1 Meetings of the Board of Directors may be called by the Secretary, or by the Group Chairman or by four Directors who give written notice to the Secretary specifying the business to be carried out. The Secretary shall send a written notice to all Directors as soon as possible after receipt of such a request.

4.2.2 The Secretary shall call a meeting on at least fourteen but not more than twenty-eight days' notice to discuss the specified business. If the Secretary fails to call such a meeting then the Group Chairman or four Directors, whichever is the case, shall call such a meeting.

4.3 Notice of Meetings

Before each meeting of the Board of Directors, a notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Group Chairman or by an officer of the Trust authorised by the Group Chairman to sign on his/her behalf shall be delivered to every Director by hand or via e-mail, sent by post to the usual place of residence of such Director, and advertised on the Trust's website so as to

be available to him/her at least three clear days before the meeting. Lack of service of the notice on any Director shall not affect the validity of a meeting.

4.3.1 Notwithstanding the above requirement for notice, the Group Chairman may waive notice in the case of emergencies or in the case of the need to conduct urgent business or on written receipt of the agreement of at least two-thirds of Directors (Group Executive and Group Non-Executive Directors taken together) but to include a minimum of two Group Executive Directors and two Group Non-Executive Directors.

4.3.2 In the case of a meeting called by Directors in default of the Group Chairman, the notice shall be signed by those Directors and no business shall be transacted at the meeting other than that specified in the notice.

4.3.3 Agendas and any supporting papers will, normally, be sent to Directors so to arrive no later than five days before the meeting but will certainly be dispatched no later than three clear days before the meeting, save in emergency. Subject to paragraph 4.3.1, failure to serve such a notice on more than three Directors will invalidate the meeting. A notice will be presumed to have been served 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

4.3.4 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors. As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the meeting to the Council of Governors.

4.4 **Notice of Extraordinary Meetings**
At the request of the Group Chairman or by at least one-third of the whole number of members of the Board, the Trust Secretary shall send a written notice to all Directors within 14 (fourteen) days of receipt of such a request specifying the date and place to discuss the specified business.

4.4.1 If the Trust Secretary fails to call such a meeting, then the Group Chair or at least one-third of the whole number of members of the Board, whichever is the case, shall call such a meeting.

4.5 **Setting of the Agenda** – The Board of Directors may determine that certain matters shall appear on every agenda for a meeting of the Board of Directors and shall be addressed prior to any other business being conducted.

4.5.1 A Director desiring a matter to be included on an agenda shall make his/her request in writing to the Group Chair at least 10 clear days before the meeting. The request should state whether the item of business should be taken in a closed session i.e. not open to the public, press or staff be transacted in the presence of the public.

4.5.2 Clear rationale and any appropriate supporting information should be provided in support of the request. Requests made less than 10 days before a meeting may be included on the agenda at the discretion of the Group Chairman.

4.5.3 Before holding a meeting, the Trust Secretary must send a copy of the agenda of the Board meeting to the Council of Governors.

4.6 **Petitions** - Where a petition has been received by the Trust, the Group Chairman of the Board of Directors shall include the petition as an item for the agenda of the next Board of Directors meeting.

4.7 **Chair of Meeting**
At any meeting of the Board of Directors, the Group Chairman, if present, shall preside. If the Group Chairman is absent from the meeting or absent temporarily on the grounds of a declared conflict of interest the Group Deputy Chairman, if present, shall preside. If the Group Chairman and Group Deputy Chairman are absent, or are disqualified from participating, another Group Non-Executive Director, as the Directors determine shall choose who shall preside.

4.8 **Annual Members' Meeting**
The Trust will publicise and hold an Annual Members' Meeting, in accordance with paragraph 11 of the Constitution.

4.9 **Notices of Motion** - A Director of the Board desiring to move or amend a motion shall send a written notice thereof at least 10 clear days before the meeting to the Group Chairman, who shall insert in the agenda for the meeting all notices so received subject to the notice being permissible under the appropriate regulations. This paragraph shall not prevent any motion being moved during the meeting, without notice on any business mentioned on the agenda subject to paragraph 4.5 above.

4.10 **Withdrawal of Motion or Amendments** - A motion or amendment once moved and seconded may be withdrawn by the proposer with the concurrence of the seconder and the consent of the Group Chairman.

4.11 **Motion to Rescind a Resolution** - Notice of motion to amend or rescind any resolution (or the general substance of any resolution) which has been passed within the preceding six calendar months shall bear the signature of the Director who gives it and also the signature of four other Directors. When any such motion has been disposed of by the Board of Directors, it shall not be competent for any Director other than the Group Chairman to propose a motion to the same effect within six months; however the Group Chairman may do so if he/she considers it appropriate.

4.12 **Motions** - The mover of a motion shall have a right of reply at the close of any discussion on the motion or any amendment thereto.

4.12.1 When a motion is under discussion or immediately prior to discussion it shall be open to a Director to move:

- an amendment to the motion.
- the adjournment of the discussion or the meeting.
- that the meeting proceed to the next business(*)
- the appointment of an ad hoc committee to deal with a specific item of business.
- that the motion be now put. (*)
- a motion under paragraph 4.1.1.

*In the case of sub-paragraphs denoted by (*) above to ensure objectivity, motions may only be put by a Director who has not previously taken part in the debate and who is eligible to vote.

4.12.2 No amendment to the motion shall be admitted if, in the opinion of the Group Chairman of the meeting, the amendment negates the substance of the motion.

4.13 **Group Chairman's Ruling**

Statements of Directors made at meetings of the Board of Directors shall be relevant to the matter under discussion at the material time and the decision of the Group Chairman of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

4.14 **Voting**

Every question/decision put to a vote at a meeting shall be determined by a majority of the votes of the Group Chairman of the meeting and members present/participating and voting on the decision and, in the case of the number of votes for and against a motion being equal, the Group Chairman of the meeting shall have a second or casting vote. No resolution of the Board of Directors shall be passed if it is opposed by all of the Group Non-Executive Directors present or by all of the Group Executive Directors present.

4.14.1 All questions/decisions put to the vote shall, at the discretion of the Group Chairman of the meeting, be determined or by a show of hands, or if meeting is being held virtually (video or teleconferencing) via the associated electronic or verbal communication channels. A paper ballot may also be used if a majority of the Directors present/participating so request.

4.14.2 If at least one-third of the Directors present/participating so request, the voting (other than by paper ballot) on any question may be recorded to show how each Director present voted or abstained.

4.14.3 If a Director so requests, his/her vote shall be recorded by name upon any vote (other than by paper ballot).

4.14.4 The Board of Directors may agree that its members can participate in its meetings by telephone, video or computer link. Participation in a meeting in this manner shall be deemed to constitute presence in person at the meeting and thus entitled to vote.

4.14.5 An officer who has been appointed formally by the Board of Directors to act up for a Group Executive Director during a period of incapacity or temporarily to fill a Group Executive Director vacancy, shall be entitled to exercise the voting rights of the Group Executive Director. An officer attending the Board of Directors to represent a Group Executive Director during a period of incapacity or temporary absence without formal acting up status may not exercise the voting rights of the Group Executive Director. An officer's status when attending a meeting shall be recorded in the minutes.

4.14.6 In no circumstances may an absent Director vote by proxy. Absence is defined as being absent at the time of the vote.

4.15 **Minutes**

The Minutes of the proceedings of a meeting shall be drawn up and maintained as a permanent record. They will be submitted for agreement at the next ensuing meeting where they will be signed by the Group Chairman presiding at it.

4.15.1 No discussion shall take place upon the minutes except upon their accuracy or where the Group Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded at the next meeting.

4.15.2 Minutes shall be circulated in accordance with the Directors' wishes. The minutes shall be made available to the Council of Governors. The minutes shall be made available to the public except for minutes relating to business conducted when members of the public are excluded under these Standing Orders.

4.16 **Waiver/Suspension of Standing Orders**

4.16.1 Except where this would contravene any provision of the Constitution or any direction made by NHS England, any one or more of the Standing Orders may be suspended at any meeting, provided that at least 50% of the Board of Directors are present, including two Group Executive Directors and two Group Non-Executive Directors, and that a majority of those present vote in favour of suspension.

4.16.2 A decision to suspend Standing Orders shall be recorded in the minutes of the meeting.

4.16.3 A separate record of matters discussed during the suspension of Standing Orders shall be made and shall be available to the Group Chairman and Board of Directors.

4.16.4 No formal business may be transacted while Standing Orders are suspended.

4.16.5 The Audit Committee shall review every decision to suspend Standing Orders.

4.17 **Variation and Amendment of Standing Orders**

These Standing Orders shall be amended only if:

- the variation proposed does not contravene a statutory provision
- at least two-thirds of the Directors are present; and
- no fewer than half the total of the Trust's Group Non-Executive Directors vote in favour of amendment.

4.18 **Record of Attendance**

4.18.1 The names of the Group Chairman and Directors and all others present at the meeting (other than members of the public and media) who are present at the meeting shall be recorded in the minutes.

4.18.2 A meeting of the Board refers to officers being physically present and officers being present via the use of technology.

4.19 **Quorum**

4.19.1 No business shall be transacted at a meeting of the Board unless at least one-third of the whole number of voting Directors are present including at least three Group Executive Directors and three Group Non-Executive Directors.

4.19.2 An officer in attendance for a Group Executive Director but without formal acting up status may not count towards the quorum.

4.19.3 If the Group Chairman or Director has been disqualified from participating in the discussion on any matter and/or from voting on any resolution by reason of the declaration of a conflict of interest he/she shall no longer count towards the quorum.

4.19.4 If a quorum is then not available for the discussion and/or the passing of a resolution on any matter, that matter may not be discussed further or voted upon at that meeting. Such a position shall be recorded in the minutes of the meeting. The meeting must then proceed to the next business.

4.19.5 Board Directors may participate (and vote) in its meetings by telephone teleconference, video or computer link. Participation in a meeting in this manner shall be deemed to constitute present in person at the meeting.

4.20 **Meetings – Electronic Communication**

4.20.1 Within these SOs, communication and electronic communication shall have the meanings as set out in the Electronic Communications Act 2000 or any statutory modification or re-enactment thereof.

4.20.2 A Director in electronic communication with the Group Chairman and all other parties to a meeting of the Board or of a standing Committee of the Board shall be regarded for all purposes as being present and personally attending such a meeting provided that, but only for so long as, at such a meeting he has the ability to communicate interactively and simultaneously with all other parties attending the meeting including all persons attending by way of electronic communication.

4.20.3 For meetings to be held in accordance with these SO for such a meeting to be quorate, quorum must be present and maintained throughout a meeting.

4.20.4 Minutes of a meeting held in this way must state that it was held by electronic communication.

5. ARRANGEMENTS FOR THE EXERCISE OF FUNCTIONS BY DELEGATION

5.1 The 2006 Act provides for all powers of the Trust to be exercised by the Board on its behalf. It also states that the Board may delegate any of its powers to a committee of Directors or to a Group Executive Director, in each case subject to such restrictions and conditions as the Board of Directors considers appropriate.

5.2 **Emergency Powers**

5.2.1 The powers which the Board of Directors has retained to itself within these Standing Orders (Standing Order 3) may in emergency be exercised by the Group Chief Executive and the Group Chairman after having consulted at least two Group Non-Executive Directors.

5.2.2 The exercise of such powers by the Group Chief Executive and Group Chairman shall be reported to the next formal meeting of the Board of Directors held in public for ratification.

5.3 Delegation to Committees

The Board of Directors:

- May appoint committees with a membership wholly of Group Directors to exercise any of its powers
- May appoint working groups consisting wholly or partly of members who are not directors for any purpose which is calculated or likely to contribute to or assist it in the exercise of its powers but it may not delegate the exercise of any of its powers to such a group. The power to appoint groups under this SO is delegated to the Group Chief Executive.
- shall agree from time to time to the delegation of executive powers to be exercised by committees, sub-committees or joint-committees, which it has formally constituted in accordance with its powers of delegation. The constitution and terms of reference of these committees, or sub-committees, or joint committees, and their specific executive powers shall be approved by the Board of Directors.

5.4 Delegation to Officers

5.4.1 Those functions of the Trust which have not been retained as reserved by the Board of Directors or delegated to a committee, sub-committee or joint-committee shall be exercised on behalf of the Board of Directors by the Group Chief Executive. The Group Chief Executive shall determine which functions he/she will perform personally and shall nominate Executive Directors / Officers to undertake the remaining functions for which he/she will still retain accountability to the Board of Directors.

5.4.2 The Group Chief Executive shall prepare a Scheme of Delegation identifying his/her proposals which shall be considered and approved by the Board of Directors, subject to any amendment agreed during the discussion. The Group Chief Executive may periodically propose amendment to the Scheme of Delegation that shall be considered and approved by the Board of Directors as indicated above.

5.4.3 Nothing in the Scheme of Delegation shall impair the discharge of the direct accountability to the Board of the Executive Directors to provide information and advise the Board of Directors in accordance with the Constitution, conditions of the License or any statutory requirements or provisions required by NHS England. Outside these statutory requirements the roles of the Group Chief Finance Officer shall be accountable to the Group Chief Executive for operational matters.

5.4.4 The arrangements made by the Board of Directors as set out in the Scheme of Delegation shall have effect as if incorporated in these Standing Orders.

5.5 Non-compliance with Standing Orders

5.5.1 If for any reason these Standing Orders are not complied with, full details of the non-compliance and any justification for non- compliance and the circumstances around the non-compliance, shall be reported to the next formal meeting of the Board of Directors for action or ratification.

5.5.2 All staff have a duty to disclose any potential or impending non-compliance to their Group Executive Director who in turn has a duty to report to the Group Chief Executive and Group Chairman as soon as possible.

6. COMMITTEES

6.1 The Board shall appoint an Audit Committee of Group Non-Executive Directors to perform such monitoring, reviewing and other functions as appropriate in accordance with these SOs and the constitution at paragraph 39.

6.2 The Board shall appoint a Committee of Group Non-Executive Directors to decide the remuneration and allowances, and other terms and conditions of office, of the Group Executive Directors in accordance with these SOs and the Constitution paragraph 33.

6.3 Subject to the 2006 Act and any such regulatory framework or guidance issued by NHS England, the Board may appoint standing committees of the Board.

6.4 There are no requirements to hold meetings of committees in public.

6.5 The Standing Orders of the Board of Directors, as far as they are applicable, shall apply with appropriate alteration to meetings of any committees established by the Board of Directors. In which case the term “Chair” is to be read as a reference to the Group Chairman of the committee as the context permits.

6.6 Each such committee shall have such terms of reference and powers and be subject to such conditions (as to reporting back to the Board of Directors), as the Board of Directors shall decide and shall be in accordance with any legislation and regulation or direction issued by NHS England. Such terms of reference shall have effect as if incorporated into the Standing Orders.

6.7 Where committees are authorised to establish sub-committees they may not delegate executive powers to the sub-committee unless expressly authorised by the Board of Directors.

6.8 The Board of Directors shall approve the appointments to each of the committees which it has formally constituted. Where the Board determines, and regulations permit, that persons, who are neither officers nor Directors, shall be appointed to a committee the terms of such appointment shall be within the powers of the Board of Directors.

6.9 The Board of Directors shall define the powers of such appointees and shall agree allowances, including reimbursement for loss of earnings, and/or expenses in accordance where appropriate with national guidance.

6.10 The Board of Directors may establish other committees, sub committees and joint committees which will work as working groups, including ad hoc committees, sub committees and joint committees at its discretion without requirement to amend these SOs.

7. CONFIDENTIALITY

7.1 A Director or appointee of a committee, sub-committee or joint committee or working group shall not disclose a matter dealt with, by, or brought before, the relevant committee without its permission until the committee sub-committee or joint committee or working group has reported to the Board of Directors or shall otherwise have concluded on that matter.

7.2 A Director or an appointee of a committee, sub-committee or joint committee shall not disclose any matter reported to the Board of Directors otherwise dealt with by the relevant committee, notwithstanding that the matter has been reported or action has been concluded, if the Board of Directors or committee shall resolve that it is confidential.

8. DECLARATION OF INTERESTS AND REGISTER OF INTERESTS

8.1 Declaration of Interests

8.1.1 All Board members, all Directors, Governors and Officers have a duty to avoid a situation in which they have (or can have) a direct or indirect interest that conflicts (or may conflict) with interests of the Trust. Any Director who has an interest in a matter that he/she is required to declare in accordance with paragraph 32 of the Trust's Constitution shall declare such interest to the Board and:

- shall withdraw from the meeting and play no part in the relevant discussion or decision; and
- shall not vote on the issue (and if inadvertence they do remain and vote, their vote shall not be counted).

8.1.2 Details of any such interest shall be recorded in the Register of Interests of Board members. At the time Board members' interests are declared, they should be recorded in the Board of Directors minutes. Any changes in interests shall be declared in accordance with the requirements of the Trust's constitution, these SOs and the Trust associated Policy.

8.1.3 Any Board member who fails to disclose any interest required to be disclosed under the preceding clause must permanently vacate their office if required to do so by a majority of the remaining Board members and, in the case of a Group Non-Executive Director, by the requisite majority of the Council of Governors.

8.1.4 Board members' directorships of companies which may conflict with their management responsibilities shall be published or referenced in the Trust's annual report. As the Trust maintains a Register of Interests which is open to the public, the disclosure included or reference within the annual report at the discretion of the Board, be limited to a comment on how access to the information in that Register may be obtained.

8.1.5 During the course of a Board meeting, if a conflict of interest is established, the Board member concerned should withdraw from the meeting and play no part in the relevant discussion or decision.

8.1.6 If Board members have any doubt about the relevance of an interest, this should be discussed with the Group Chairman or Trust Secretary.

8.2 Register of Interests

8.2.1 The Group Chief Executive will ensure that a Register of Interests is established to record formally declarations of interests of Directors. In particular the Register will include details of all directorships and other interests which have been declared by both Group Executive and Group Non-Executive Board members, in accordance with paragraphs 32 and 36 of the Trust's Constitution.

8.2.2 The Trust Secretary will keep these details up to date by means of an annual review of the Register in which any changes to interests declared during the preceding twelve months will be incorporated. It is the responsibility of each Board member to provide an update to the Trust Secretary of their register entry if their interest changes.

8.2.3 The Register will be available to the public and the Group Chief Executive will take reasonable steps to bring the existence of the Register to the attention of the local population and to publicise arrangements for viewing it.

8.3 **Register of Gifts and Hospitality**

8.3.1 A Register of Gifts and Hospitality will be maintained by the Trust Secretary for the Board members, staff, all prospective employees – who are part-way through recruitment, Contractors and sub-contractors, Agency staff; and Committee, sub-committee and advisory group members (who may not be directly employed or engaged by the organisation).

8.3.2 The Register will be published on the Trust's website in line with regulatory requirements.

9. DISABILITY OF DIRECTORS IN PROCEEDINGS ON ACCOUNT OF PECUNIARY INTEREST

9.1 Subject to the following provisions of this Standing Order, if the Group Chairman or a Director has any pecuniary interest, direct or indirect, in any contract, proposed contract or other matter and is present at a meeting of the Board of Directors at which the contract or other matter is the subject of consideration, he/she shall at the meeting and as soon as practicable after its commencement disclose the fact and shall not take part in the consideration or discussion of the contract or other matter or vote on any question with respect to it.

9.2 The Board of Directors may exclude the Group Chairman or a Director from a meeting of the Board of Directors while any contract, proposed contract or other matter in which he/she has a pecuniary interest, is under consideration.

9.3 The Board, as it may think fit, may remove any disability imposed by this Standing Order in any case in which it appears to the Board that, in the interests of the Trust, the disability shall be removed.

9.4 Such action shall have the support of at 50% of the Directors present at the meeting (including two Group Executive and two Group Non-Executive Directors).

9.5 Any remuneration, compensation or allowances payable to the Group Chairman or a Director by the Trust shall not be treated as a pecuniary interest for the purpose of this Standing Order.

9.6 For the purpose of this SO the Group Chairman and Director shall be treated, subject to these SOs as having indirectly a pecuniary interest in a contract, proposed contract or other matter, if:

9.6.1 he/she, or a nominee of his/her, is a director of a company or other body, not being a public body, with which the contract was made or is proposed to be made or which has a direct pecuniary interest in the other matter under consideration; or

9.6.2 he/she is a partner of, or is in the employment of a person with whom the contract was made or is proposed to be made or who has a direct pecuniary interest in the other matter under consideration; and

9.6.3 In the case of family, or, close personal relationships the interest of one party shall, if known to the other, be deemed for the purposes of these SOs to be also an interest of the other.

9.7 The Group Chairman or a Director shall not be treated as having a pecuniary interest in any contract, proposed contract or other matter by reason only:

9.7.1 of his/her membership of a company or other body, if he/she has no beneficial interest in any securities of that company or other body;

9.7.2 of an interest in any company, body or person with which he/she is connected as mentioned above which is so remote or insignificant that it cannot reasonably be regarded as likely to influence a Director in the consideration or discussion of or in voting on, any question with respect to that contract or matter.

9.8 Where the Group Chairman or Director:

9.8.1 has an indirect pecuniary interest in a contract, proposed contract or other matter by reason only of a beneficial interest in securities of a company or other body; and

9.8.2 the total nominal value of those securities does not exceed £5,000 or one-hundredth of the total nominal value of the issued share capital of the company body, whichever is the less; and

9.8.3 if the share capital is of more than one class, the total nominal value of shares of any one class in which he/she has a beneficial interest does not exceed one-hundredth of the total issued share capital of that class;

this Standing Order shall not prohibit him/her from taking part in the consideration or discussion of the contract or other matter or from voting on any question with respect to it, without prejudice however to his/her duty to disclose his/her interest.

9.9 These SOs applies to a committee or sub-committee and to a joint committee as it applies to the Board of Directors and applies to an appointee of any such committee or sub-committee (whether or not he/she is also a Director of the Trust) as it applies to a Director of the Trust.

10. STANDARDS OF BUSINESS CONDUCT POLICY

10.1 **Policy**

Staff should comply with the Trust's Constitution and the National Guidance Standards of Business Conduct for NHS Staff – "managing conflicts of interest in the NHS", which came into force on 1 June 2017. This guidance supersedes and extinguishes HSG (93)5 Standards of Business Conduct for NHS Staff. This guidance requires all NHS organisations to meet strict ethical standards in the conduct of any NHS business.

10.2 **Interests of Directors, Officers, all staff, Consultants, Contractors and Governors**

If it comes to the knowledge of a Director or Officer (the term officer in this instance includes all staff, consultants, contractors and Governors) of the Trust that a contract in which he/she has any pecuniary interest not being a contract to which he/she is himself/herself a party, has been, or is proposed to be, entered into by the Trust he/she shall, at once, give notice in writing to the Group Chief Executive of the fact that he/she is interested therein. In the case of persons living together as partners, the interest of one partner shall, if known to the other, be deemed to be also the interest of that partner.

10.2.1 A Director should also declare to the Group Chief Executive any other employment or business or other relationship of his/her, or of a spouse/partner/other family member, that conflicts, or might reasonably be predicted could conflict with the interests of the Trust comply with the SOs, SFI, the financial limits specified in the SoRD, and the Trust's Tendering and Quotation Policy and Procedure.

10.3 **Legislation Governing Public Procurement**

10.3.1 The Trust shall comply with the Public Contracts Regulations 2015 (the 'Regulations') as applicable and any other duties derived from the UK common law ('Common Law Duties') . The Regulations and Common Law Duties together are referred to elsewhere in these SOs as 'Procurement Legislation'.

10.3.2 The Trust should consider obtaining support from the NHS Supply chain and/or Cabinet Office where relevant and/or any suitably qualified professional advisor (including where appropriate legal advisors to ensure compliance with Procurement Legislation when engaging in tendering procedures).

10.3.3 When procuring services, the Trust should have regard to the requirements of the Public Services (Social Value) Act 2012 and its supporting regulations and guidance, as amended.

10.4 **Guidance on Procurement and Commissioning**

The Trust should have due regard to all relevant guidance issued in relation to the conduct of procurement practice.

10.5 **Formal Competitive Tendering**

10.5.1 The Trust shall ensure that competitive tenders are invited for the supply of goods, materials and manufactured articles and for the rendering of services including all forms of management consultancy services: for the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); and for disposals when so required by any

Procurement Legislation or as otherwise set out in the Trust's Tendering and quotation Policy and Procedure and/or the SoRD.

10.5.2 Formal tendering procedures may be waived by officers to whom powers have been delegated by the Group Chief Executive in accordance with the Trust's Policy and Procedure. All such waivers should be reported to the next available meeting of the Audit Committee.

10.6. Contracts

10.6.1 The Board of Directors may only enter into contracts on behalf of the Trust within the statutory powers delegated to it and shall comply with:

- These SOs;
- The Trust's SFIs;
- other statutory provisions;

10.6.2 Any relevant and mandatory directions including NHS England's guidance Assuring and supporting complex change Statutory transactions, including mergers and acquisitions, the Department of Health and Social Care's Estate Code; and the NHS Standard Contract as applicable.

10.6.3 Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

10.6.4 In all contracts made by the Trust, the Board shall endeavour to obtain best value for money. The Group Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

10.7 Personal and Agency or Temporary Staff Contracts

10.7.1 The Group Chief Executive shall nominate officers with delegated authority to enter into contacts of employment, regarding staff, agency staff or temporary staff service contracts.

10.8 Legally Binding Contracts for the Provisions of Healthcare

Legally binding contracts for the supply of healthcare services shall be drawn up in accordance with legal advice, best practice and where possible use the NHS Standard Contract. These legally binding contracts will be administered by the Trust.

10.9 Cancellation of Contracts

10.9.1 Except where specific provision is made in the NHS Standard Terms and Conditions approved for use within the NHS, there shall be inserted in every written contract a clause empowering the Trust to cancel the contract and to recover from the contractor the amount of any loss resulting from such cancellation:

10.9.1.1 if the contractor shall have offered, or given or agreed to give, any person any gift or consideration of any kind as an inducement or reward for doing or forbearing to do or for having done or forborne to do any action in relation to the obtaining or execution of the contract or any other contract with the Trust, or for showing or

foreseeing to show favour or disfavor to any person in relation to the contracts or any other contract with the Trust; or

10.9.1.2 if any relation to any contract with the Trust the contractor or any person employed by them or action on their behalf shall have committed any offence under the Bribery Act 2010 and any other appropriate legislation.

10.10 **Determination of Contracts for Failure to Deliver Goods or Materials**

10.10.1 There shall be inserted in every written contract for the supply of goods or materials a clause to secure that, should the contractor fail to deliver the goods or materials or any portion thereon within the time or times specified in the contract, the Trust may, without prejudice, determine the contract either wholly or to the extent of such default and purchase other goods, or material of similar description to make good:

such default; or

in the event of the contract being wholly determined the goods or materials remaining to be delivered.

The clause shall further secure that the amount by which the cost of so purchasing other goods or material exceeds the amount which would have been payable to the contract in respect of the goods or materials shall be recoverable from the contractor.

11. DISPOSALS

11.1 Competitive tendering or quotation procedures shall not apply to the disposal of:

11.1.1 Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in reserve) by the Group Chief Executive or his nominated officer.

11.1.2 Obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust.

11.1.3 Items to be disposed of with an estimated sale value of less than £(n) this figure to be reviewed annually.

11.1.4 Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with relevant contract.

12. IN-HOUSE SERVICES

12.1 In all cases where the Trust determines that in-house services should be subject to competitive tendering the following groups shall be set up:

12.2 Specification group, comprising the Group Chief Executive or nominated officer(s) and specialist(s).

12.3 In-house tender group, comprising representatives of the in-house team, a nominee of the Group Chief Executive and technical support.

12.4 Evaluation team comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £(n), a non-officer member should be a member of the evaluation team.

12.5 All groups should work independently of each other, but individual officers may be a member of more than one group. No member of the in-house tender group may participate in the evaluation of tenders.

12.6 The evaluation group shall made recommendations to a Committee of the Board of Directors and/or Board.

13. CUSTODY OF SEAL AND SEALING OF DOCUMENTS

13.1 **Requirements to seal**

It is a legal requirement to place any property transactions e.g. purchase, sale, and lease, under seal.

13.1.1 Other contracts/documentation should be approved by an authorised signatory 'under hand' i.e. signed.

13.2 **Custody of Seal**

13.2.1 The Common Seal of the Trust shall be kept by the Trust Secretary on behalf of the Group Chief Executive in a secure place.

13.3 **Sealing of Document**

13.3.1 The Board delegates authority to the Group Chairman (or a Group Non-Executive Director) and the Group Chief Executive (or another Group Executive Director, but excluding the Group Chief Finance Officer) to apply the seal on behalf of the Trust to any document required to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any committee or sub-committee to which the Board has delegated appropriate authority

13.3.2 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed. The Trust is to have a seal, but this is not to be affixed except under the authority of the Board of Directors.

13.4 **Register of Sealing**

An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the seal. A report of all sealings shall be made to the Board at least quarterly. The report shall contain details of the seal number, the description of the document, date of sealing and the names of persons who attested the fixing of the seal or who executed the Deed on behalf of the Trust.

14. SIGNATURE OF DOCUMENTS

14.1 Where the signature of any document will be a necessary step in legal proceedings involving the Trust, it shall be signed by the Group Chief Executive or an officer acting on his/her behalf, unless any enactment otherwise requires or authorises, or the Board of Directors shall have given the necessary authority to some other person for the purpose of such proceedings.

14.2 The Group Chief Executive or nominated officers shall be authorised, by resolution of the Board of Directors, to sign on behalf of the Trust any agreement or other document not requested to be executed as a deed, the subject matter of which has been approved by the Board of Directors or any committee or sub-committee to which the Board has delegated appropriate authority.

15. MISCELLANEOUS

15.1 **Standing Orders to be given to Board Members and Officers**
It is the duty of the Group Chief Executive to ensure that existing Directors and Officers and all new appointees are notified of and understand their responsibilities within Standing Orders and Standing Financial Instructions. Updated copies shall be issued to staff designated by the Group Chief Executive. New designated officers shall be informed in writing and shall receive copies where appropriate of the Standing Orders.

15.2 **Documents having the standing of Standing Orders**
Standing Financial Instructions and Reservation of Powers to the Board and Delegation of Powers shall have effect as if incorporated into Standing Orders.

15.3 **Review of Standing Orders**
Standing Orders shall be reviewed annually by the Board of Directors. The requirement for review extends to all documents having the effect as if incorporated in SOs.

15.4 **Dispute Resolution**

15.4.1 Where there is a dispute between the Board of Directors and the Council of Governors in connection with the constitution, including the interpretation of these SOs and the procedure to be followed at meetings of the Board, the Group Chairman (or Group Senior Independent Director or Group Deputy Chairman if the dispute involves the Group Chairman) will endeavour to resolve the dispute informally, through discussions with the Council of Governors.

15.4.2 Where a dispute arises that involves the Group Chairman, the dispute shall be referred to the Group Senior Independent Director who will use all reasonable efforts to mediate a settlement to the dispute.

15.4.3 The Group SID also acts as the point of contact for Governors with the Board of Directors during the Group Chairman's annual performance appraisal process (includes remuneration and other allowances).

15.4.4 The Council of Governors should only exercise its power to remove the Group Chairman, or any other Group Non-Executive Director, after exhausting all means of engagement with the Board.

15.4.5 In the event of any unresolved dispute between the Board of Directors and the Council of Governors, the Group Chairman or the Secretary may arrange for independent professional advice to be obtained for the Trust. The Group Chairman may also initiate an independent review to investigate and make recommendations in respect of how the dispute may be resolved.

15.4.6 For avoidance of doubt, the Trust Secretary shall deal with any membership queries and other similar questions in the first instance including any voting or legislation issues and shall otherwise follow up process of resolving such matters in accordance with any procedures agreed by the Board.

ANNEX 7

Further Provisions

1. DISQUALIFICATION FROM MEMBERSHIP

1.1 An individual may not become a member of the Trust if:

1.1.1 they are under 11 years of age; or

1.1.2 within the last five years they have been involved as a perpetrator in a serious incident of violence at any of the Trust's hospitals or facilities or against any of the Trust's employees or other persons who exercise functions for the purposes of the Trust, or against any registered volunteer.

2. TERMINATION OF MEMBERSHIP

2.1 A member shall cease to be a member if:

2.1.1 they resign by notice to the Secretary;

2.1.2 they die;

2.1.3 they are expelled from membership under this Constitution;

2.1.4 they cease to be entitled under this Constitution to be a member of a Public Constituency or of any of the classes of the Staff Constituency;

2.1.5 it appears to the Secretary that they no longer wish to be a member of the Trust, and after enquiries made in accordance with a process approved by the Council of Governors, they fail to demonstrate that they wish to continue to be a member of the Trust.

2.2 A member may be expelled by a resolution approved by not less than two-thirds of the Governors present and voting at a General Meeting. The following procedure is to be adopted.

2.2.1 Any member may complain to the Secretary that another member has acted in a way detrimental to the interests of the Trust.

2.2.2 If a complaint is made, the Council of Governors may itself consider the complaint having taken such steps as it considers appropriate to ensure that each member's point of view is heard and may either:

2.2.2.1 dismiss the complaint and take no further action; or

2.2.2.2 for a period not exceeding twelve months suspend the rights of the member complained of to attend members meetings and vote under this Constitution;

2.2.2.3 arrange for a resolution to expel the member complained of to be considered at the next General Meeting of the Council of Governors.

2.2.3 If a resolution to expel a member is to be considered at a General Meeting of the Council of Governors, details of the complaint must be sent to the member complained of

not less than one calendar month before the meeting with an invitation to answer the complaint and attend the meeting.

2.2.4 At the meeting the Council of Governors will consider evidence in support of the complaint and such evidence as the member complained of may wish to place before them.

2.2.5 If the member complained of fails to attend the meeting without due cause the meeting may proceed in their absence.

2.3 A person expelled from membership will cease to be a member upon the declaration by the Group Chairman of the meeting that the resolution to expel them is carried.

2.4 No person who has been expelled from membership is to be re-admitted except by a resolution carried by the votes of two-thirds of the Council of Governors present and voting at a General Meeting.

REPRESENTATIVE MEMBERSHIP

2.5 The Trust shall at all times strive to ensure that taken as a whole its actual membership is representative of those eligible for membership. To this end:

2.5.1 the Trust shall at all times have in place and pursue a membership strategy which shall be approved by the Council of Governors, and shall be reviewed by them from time to time, and at least every three years,

2.5.2 the Council of Governors shall present to each Annual Members' Meeting a report on:

2.5.2.1 steps taken to secure that (taken as a whole) the actual membership of the Public Constituencies is representative of those eligible for such membership and the progress of the membership strategy;

2.5.2.2 any changes to the membership strategy.

COMMITMENTS

2.6 The Trust shall exercise its functions effectively, efficiently and economically.

Co-operation with NHS Bodies and Local Authorities

2.7 In exercising its functions, the Trust shall co-operate with NHS bodies and local authorities.

Openness

2.8 In conducting its affairs, the Trust shall have regard to the need to provide information to members and conduct its affairs in an open and accessible way.

Prohibiting Distribution

2.9 The profits or surpluses of the Trust are not to be distributed either directly or indirectly in any way at all among members of the Trust.

3. FRAMEWORK

3.1 The affairs of the Trust are to be conducted by the Board of Directors, the Council of Governors and the members in accordance with this Constitution and the Trust's licence. The members, the Council of Governors and the Board of Directors are to have the roles and responsibilities set out in this Constitution.

Members

3.2 Members may attend and participate at members' meetings, vote in elections to, and if eligible, stand for election to, the Council of Governors, and take such other part in the affairs of the Trust as is provided in this Constitution.

Council of Governors

3.3 The roles and responsibilities of the Council of Governors, which are to be carried out in accordance with this constitution and the Trust's License, are outlined in 16.1, 26.1, 28.2, 33.1, 38.3, 44.1.1 and 45.1 of the Constitution.

3.4 Additional roles and responsibilities include:

3.4.1 to discharge their duty to represent the public, Councils of Governors are required to take account of the interests of the public at large. This includes the population of the local system of which the Trust is part and the whole population of England as served by the wider NHS.

3.4.2 to respond as appropriate when consulted by the Board of Directors in accordance with this constitution;

3.4.3 to undertake such matters as the Board of Directors shall from time to time request;

3.4.4 to prepare and from time to time review the Trust's membership strategy and its policy for the composition of the Council of Governors and of the Group Non-Executive Directors and when appropriate to make recommendations for the revision of this Constitution.

Board of Directors

3.5 The business of the Trust is to be managed by the Board of Directors, who shall exercise all the powers of the Trust, subject to any contrary provisions of the 2006 Act as given effect by this Constitution.

4. Secretary

4.1 The Trust shall have a Secretary who may be an employee. The Secretary may not be a Governor, or the Group Chief Executive or the Finance Director. The Secretary's functions shall include:

4.1.1 acting as Secretary to the Council of Governors and the Board of Directors, and any committees;

4.1.2 summoning and attending all Members' meetings, meetings of the Council of Governors and the Board of Directors, and keeping the minutes of those meetings;

4.1.3 keeping the register of members and other registers and books required by this Constitution to be kept;

4.1.4 having charge of the Trust's seal;

4.1.5 publishing to members in an appropriate form information which they should have about the Trust's affairs;

4.1.6 preparing and sending to NHS England and any other statutory body all returns which are required to be made.

4.1.7 the Secretary shall make the final decision about the staff class of which an individual is eligible to be a member.

4.2 Minutes of every Members' meeting, of every meeting of the Council of Governors and of every meeting of the Board of Directors are to be kept. Minutes of the Council of Governors' and Board of Directors' meetings will be read at the next meeting and signed by the Group Chairman of that meeting. The Council of Governors will approve the minutes of Members' meeting. The signed or approved minutes will be conclusive evidence of the events of the meeting.

4.3 The Secretary is to be appointed and removed by the Board of Directors.

5. FURTHER PROVISIONS AS TO ACCOUNTS

5.1 The following documents will be made available to the Comptroller and Auditor General for examination at his request:

5.1.1 the accounts;

5.1.2 any records relating to them; and

5.1.3 any report of the auditor on them.

5.2 In preparing its annual accounts, the Accounting Officer shall cause the Trust to keep proper accounts and proper records in relation to the accounts that comply with any directions given by NHS England with the approval of the Secretary of State as to:

5.2.1 the methods and principles according to which the accounts are to be prepared;

5.2.2 the information to be given in the accounts;

and shall be responsible for the functions of the Trust as set out in paragraph 25 of Schedule 7 to the 2006 Act.

5.3 The Accounting Officer shall cause the Trust to:

5.3.1 lay a copy of the annual accounts, and any report of the auditor on them, before Parliament; and

5.3.2 once it has done so, send copies of those documents to NHS England.

6. FURTHER PROVISIONS AS TO ANNUAL REPORTS

6.1 The annual reports are to give:

6.1.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of the Public Constituency and of the classes of the Staff Constituency is representative of those eligible for such membership;

6.1.2 information on any occasions in the period to which the report relates on which the Council of Governors exercised its powers under paragraph 33.2 and such other procedures as the Trust has on pay;

6.1.3 information on the remuneration of the directors and on the expenses of the governors and the directors;

6.1.4 any other information NHS England requires.

6.2 The Trust is to comply with any decision NHS England makes as to:

6.2.1 the form of the reports;

6.2.2 when the reports are to be sent to it;

6.2.3 the periods to which the reports are to relate.

7. DISPUTE RESOLUTION PROCEDURES (Non-Council of Governors related)

7.1 Every unresolved dispute which arises out of this Constitution between the Trust and:

7.1.1 a member; or

7.1.2 any person aggrieved who has ceased to be a member within the six months prior to the date of the dispute; or

7.1.3 any person bringing a claim under this Constitution; or

7.1.4 an office-holder of the Trust

is to be submitted to an arbitrator agreed by the parties or in the absence of agreement to be nominated by NHSE. The arbitrator's decision will be binding and conclusive on all parties.

7.2 Any person bringing a dispute must, if required to do so, deposit with the Trust a reasonable sum (not exceeding £250) to be determined by the Council of Governors and approved by the Secretary. The arbitrator will decide how the costs of the arbitration will be paid and what should be done with the deposit.

8. DISSOLUTION

The Trust may not be dissolved except by order of the Secretary of State for Health, in accordance with the 2006 Act.

9. HEAD OFFICE

The Trust's head office is at Cobbett House, Oxford Road, Manchester or such other place as the Board of Directors shall decide.

10. NOTICES

10.1 Any notice required by this Constitution to be given shall be given in writing or shall be given using electronic communications to an address for the time being notified for that purpose. "Address" in relation to electronic communications includes any number or address used for the purposes of such communications.

10.2 Proof that an envelope containing a notice was properly addressed, prepaid and posted shall be conclusive evidence that the notice was given. A notice shall be treated as delivered 48 hours after the envelope containing it was posted or, in the case of a notice contained in an electronic communication, 48 hours after it was sent.

ANNEX 8

Annual Members' Meeting

(Paragraph 11)

1. The Group Chairman shall be the final authority on the interpretation of these Standing Orders for the purpose of the Annual Members' Meeting (on which he shall be advised by the Group Chief Executive and the Secretary)**.**

2. Attendance

2.1 Each member shall be entitled to attend/participate an Annual Members' Meeting.

3. Meetings in Public

3.1 Annual Members' Meetings are open to all members of the Trust, Governors and Directors, representatives of the External Auditor, and to members of the public subject to the provisions in paragraph 3.2 below:

3.2 The Group Chairman may exclude any member of the public from an Annual Members' Meeting if he is interfering with or preventing the reasonable conduct of the meeting.

3.3. Annual Members' Meetings shall be held annually at such times and places or in a format as the Group Chairman may determine.

3.4 For the avoidance of doubt, the Trust may invite members to attend engagement and other events in addition to the Annual Members' Meeting.

4. Notice of Meetings

4.1. All Members' Meetings are to be convened by the Secretary by order of the Council of Governors.

4.2 A notice of the meeting, specifying the business proposed to be transacted at it, and signed by the Group Chairman, or by an officer of the Trust authorised by the Group Chairman to sign on his behalf, shall be served upon every Member, the Board of Directors, Council of Governors and to the External Auditor at least 14 clear days before the meeting and posted on the Trust's website and displayed at its headquarters. Failure of service of such a notice on any Member shall not affect the validity of a meeting.

4.3 The notice shall state whether the meeting is:

4.3.1 an annual other members' meeting (forum);
4.3.2 give the time, date, place and/or format of the meeting; and
4.3.3 indicate the business to be dealt with at the meeting.

4.4. The Annual Report and Accounts shall be circulated to Governors and published on the website at the earliest and appropriate opportunity. Copies of the Annual Report and Accounts shall be sent to any member upon written request to the

Secretary and shall be available for inspection by a member free of charge at the place of the meeting and/or in electronic format, via the Trust's website

5. Setting the Agenda

5.1. The Group Chairman shall determine the agenda for Annual Members' Meetings which must include the business required by the 2006 Act.

6. Chair of Annual Members' Meetings

6.1 The Group Chairman of the Trust, or in their absence the Group Deputy Chairman of the Board of Directors, shall act as Chair. If neither the Group Chairman or the Group Deputy Chairman of the Board of Directors is present/participating, the members of the Council of Governors present/participating shall elect one of their number to be Chair and if there is only one Governor present/participating and willing to act, they shall be Chair of the Annual Members' Meeting.

7. Chair's Ruling

7.1. Statements of members made at Annual Members' Meetings shall be relevant to the matter under discussion at that time and the decision of the Chair of the meeting on questions of order, relevancy, regularity and any other matters shall be final.

8. Voting

8.1. Decisions at meetings shall be determined by a majority of the votes of the members present/participating and voting. In the case of any equality of votes, the person presiding shall have a second or casting vote.

8.2 Where appropriate, the Trust may make arrangements for members to vote by post, or (except with regard to elections to the Council of Governors, which are subject to Annex 10) by using electronic communications.

8.3 All decisions put to the vote shall, at the discretion of the Chair of the meeting, be determined by oral expression or by a show of hands, or if meeting is being held virtually (video or teleconferencing) via the associated electronic or verbal communication channels.

8.4. In such circumstances when a member is absent member proxy voting will not be allowed at any time.

8.5. Every member present/participating and every member who has voted by post or using electronic communications is to have one vote.

9. Suspension of Standing Orders

9.1. Except where this would contravene any statutory provision, any one or more of these standing orders may be suspended at an Annual Members' Meeting, provided that a majority of members present vote in favour of their suspension.

9.2. A decision to suspend the standing orders shall be recorded in the minutes of the meeting.

9.3. A separate record of matters discussed during the suspension of the standing orders shall be made and shall be available to the members.

9.4. No formal business may be transacted while the standing orders are suspended.

9.5. The Trust's Audit Committee shall review every decision to suspend the standing orders.

10. Minutes

10.1. The minutes of the proceedings of an Annual Members' Meeting shall be drawn up and maintained as a public record. They will be submitted to the Council of Governors for agreement.

10.2. No discussion shall take place upon the minutes except upon their accuracy or where the Group Chairman considers discussion appropriate. Any amendment to the minutes shall be agreed and recorded.

10.3 The result of any vote will be declared by the Group Chairman and entered in the minute book. The minute book will be conclusive evidence of the result of the vote.

10.4. The minutes of an Annual Members' Meeting shall be made available to the public on the Trust's website.

11. Quorum

11.1. Before a Members' Meeting can do business there must be a quorum present/participating. Except where this Constitution says otherwise, a quorum is 20 members present.

11.2 If no quorum is present within half an hour of the time fixed for the start of the meeting (if meeting is being held face-to-face), the meeting shall stand adjourned to the same day in the next week at the same time and place or to such time and place as the Council of Governors determine. If a quorum is not present within half an hour of the time fixed for the start of the adjourned meeting (if meeting is being held face-to-face), the number of members present during the meeting is to be a quorum.

11.3 A resolution put to the vote at a Members' Meeting shall be decided upon by an oral expression or by show of hands unless a poll is requested by the Chair of the meeting.

ANNEX 9

Panel investigation procedure for governors

1. PANEL

1.1 A panel consisting of the Chair, the Lead Governor and two Elected and one Appointed Governors ("the Panel") shall be convened to carry out enquiries to investigate whether there are grounds to remove an existing Governor from the Council of Governors, and to recommend to the Council of Governors what action should be taken.

1.2 Where the matter concerns the Lead Governor, that individual shall be excluded from the Panel and will be substituted by a second Appointed Governor.

1.3 The Panel may at any time determine that it is in the best interests of the Trust for the Governor concerned to be suspended from the Council of Governors pending the outcome of the Panel's deliberations. Suspension is a neutral act and is not a presumption of guilt nor an indication of the Panel's eventual recommendation. Suspension shall not be applied automatically and will be considered on a case-by-case basis. The suspension of a Governor shall be reviewed by the Group Chairman after a period of fourteen (14) calendar days, and every seven (7) calendar days thereafter until such a time as the matter has been determined.

1.4 The Panel may investigate the matter itself or appoint a suitably experienced investigating officer (who may be external to the Trust) to investigate the matter and to prepare a report for the Panel.

1.5 The Governor concerned shall be invited to make written or oral representations to the Panel or to the investigating officer (or to be accompanied at his or her own cost) in respect of the matter, and such representations must be provided within a period of twenty-eight (28) days from the date of the invitation. Any representations received shall be considered by the Panel or the investigating officer as applicable.

2. DECISION BY THE PANEL

2.1 Subject to paragraph 3 below, the Panel shall make a decision on the Governor's disqualification from the Council of Governors as soon as reasonably practicable and shall give notice in writing of that decision to the Governor concerned within seven (7) days of the decision being made. The decision shall be based on a majority vote.

2.2 If the Governor concerned disputes the decision made by the Panel, the decision will be referred to an arbitrator, following which the procedure set out in paragraph 21 of the Constitution (Dispute Resolution Procedures) shall apply.

3. RECOMMENDATION BY THE PANEL TO THE COUNCIL OF GOVERNORS

3.1 Where the matter concerns allegations that:

3.1.1 the relevant Governor has committed a material breach of the Trust's code of conduct; or

3.1.2 the relevant Governor has acted in a manner detrimental to the interests of the Trust; or

3.1.3 it is not in the best interests of the Trust for the relevant Governor to continue as a Governor

as set out in Annex 4 (Additional Provisions – Council of Governors) paragraph **Error! Reference source not found.**10 of the Constitution, the Panel will make a recommendation to the Council of Governors rather than come to a decision itself. The Panel's recommendation shall be based on a majority vote and may include a recommendation to the Council of Governors to terminate the tenure of office of the Governor concerned.

3.2 The Council of Governors will consider the Panel's recommendation in private session at its next scheduled Council meeting. Where the Panel considers it appropriate for the Council of Governors to consider the recommendation earlier than the next scheduled Council meeting, the Panel may request the Secretary to convene an extraordinary Council meeting on at least seven (7) days' notice. The Council of Governors will receive representations from the Panel and from the Governor concerned. If the Governor concerned fails to attend the Council meeting without due cause, the Council meeting may proceed in their absence.

3.3 The decision of the Council of Governors will be confirmed in writing, including the reasons for the decision, to the Governor concerned by the Secretary within seven (7) days of the date of the Council meeting.

3.4 If the Governor concerned disputes the decision made by the Council of Governors, they may apply in writing to the Council of Governors within seven (7) days of the date of the written confirmation referred to in paragraph 3.3 above for the decision of the Council of Governors to be referred to an arbitrator, following which the procedure set out in Annex 5 paragraph 22 (Standing Orders for the Practice and Procedure for the Council of Governors) of the Constitution (Dispute Resolution Procedure) shall apply.

ANNEX 10

MODEL ELECTION RULES (2014)

(Paragraph 13.2)

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PART 10: ELECTION EXPENSES AND PUBLICITY

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PART 11: QUESTIONING ELECTIONS AND IRREGULARITIES

PART 12: MISCELLANEOUS

PART 1: INTERPRETATION

1. Interpretation

1.1 In these rules, unless the context otherwise requires: "*2006 Act*" means the National Health Service Act 2006;

"*corporation*" means the public benefit corporation subject to this constitution; "*council of governors*" means the council of governors of the corporation; "*declaration of identity*" has the meaning set out in rule 21.1;

"*election*" means an election by a constituency, or by a class within a constituency, to fill a vacancy among one or more posts on the council of governors;

"*e-voting*" means voting using either the internet, telephone or text message; "*e-voting information*" has the meaning set out in rule 24.2;

"*ID declaration form*" has the meaning set out in Rule 21.1; "internet voting record" has the meaning set out in rule 26.4(d);

"*internet voting system*" means such computer hardware and software, data other equipment and services as may be provided by the returning officer for the purpose of enabling voters to cast their votes using the internet;

"*lead governor*" means the governor nominated by the corporation to fulfil the role described in Appendix B to The NHS Foundation Trust Code of Governance (Monitor, December 2013) or any later version of such code.

"*list of eligible voters*" means the list referred to in rule 22.1, containing the information in rule 22.2;

"*method of polling*" means a method of casting a vote in a poll, which may be by post, internet, text message or telephone;

"*Monitor*" means the corporate body known as Monitor as provided by section 61 of the 2012 Act;

"*numerical voting code*" has the meaning set out in rule 64.2(b) "*polling website*" has the meaning set out in rule 26.1;

"*postal voting information*" has the meaning set out in rule 24.1;

"*telephone short code"* means a short telephone number used for the purposes of submitting a vote by text message;

"*telephone voting facility*" has the meaning set out in rule 26.2; "*telephone voting record*" has the meaning set out in rule 26.5 (d); "*text message voting facility*" has the meaning set out in rule 26.3; "*text voting record*" has the meaning set out in rule 26.6 (d);

"*the telephone voting system*" means such telephone voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by telephone;

"*the text message voting system*" means such text messaging voting facility as may be provided by the returning officer for the purpose of enabling voters to cast their votes by text message;

"*voter ID number*" means a unique, randomly generated numeric identifier allocated to each voter by the Returning Officer for the purpose of e-voting,

"*voting information*" means postal voting information and/or e-voting information

1.2 Other expressions used in these rules and in Schedule 7 to the NHS Act 2006 have the same meaning in these rules as in that Schedule.

PART 2: TIMETABLE FOR ELECTIONS

2. Timetable

2.1 The proceedings at an election shall be conducted in accordance with the following timetable:

Proceeding	Time
Publication of notice of election	Not later than the fortieth day before the day of the close of the poll.
Final day for delivery of nomination forms to returning officer	Not later than the twenty eighth day before the day of the close of the poll.
Publication of statement of nominated candidates	Not later than the twenty seventh day before the day of the close of the poll.
Final day for delivery of notices of withdrawals by candidates from election	Not later than twenty fifth day before the day of the close of the poll.
Notice of the poll	Not later than the fifteenth day before the day of the close of the poll.
Close of the poll	By 5.00pm on the final day of the election.

3. Computation of time

3.1 In computing any period of time for the purposes of the timetable:

(a) a Saturday or Sunday;

(b) Christmas day, Good Friday, or a bank holiday, or

(c) a day appointed for public thanksgiving or mourning,

shall be disregarded, and any such day shall not be treated as a day for the purpose of any proceedings up to the completion of the poll, nor shall the returning officer be obliged to proceed with the counting of votes on such a day.

3.2 In this rule, “bank holiday” means a day which is a bank holiday under the Banking and Financial Dealings Act 1971 in England and Wales.

PART 3: RETURNING OFFICER

4. Returning Officer

4.1 Subject to rule 69, the returning officer for an election is to be appointed by the corporation.

4.2 Where two or more elections are to be held concurrently, the same returning officer may be appointed for all those elections.

5. Staff

5.1 Subject to rule 69, the returning officer may appoint and pay such staff, including such technical advisers, as he or she considers necessary for the purposes of the election.

6. Expenditure

6.1 The corporation is to pay the returning officer:

(a) any expenses incurred by that officer in the exercise of his or her functions under these rules,

(b) such remuneration and other expenses as the corporation may determine.

7. Duty of co-operation

7.1 The corporation is to co-operate with the returning officer in the exercise of his or her functions under these rules.

PART 4: STAGES COMMON TO CONTESTED AND UNCONTESTED ELECTIONS

8. Notice of election

8.1 The returning officer is to publish a notice of the election stating:

(a) the constituency, or class within a constituency, for which the election is being held,

(b) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(c) the details of any nomination committee that has been established by the corporation,

(d) the address and times at which nomination forms may be obtained;

(e) the address for return of nomination forms (including, where the return of nomination forms in an electronic format will be permitted, the e-mail address for such return) and the date and time by which they must be received by the returning officer,

(f) the date and time by which any notice of withdrawal must be received by the returning officer

(g) the contact details of the returning officer

(h) the date and time of the close of the poll in the event of a contest.

9. Nomination of candidates

9.1 Subject to rule 9.2, each candidate must nominate themselves on a single nomination form.

9.2 The returning officer:

(a) is to supply any member of the corporation with a nomination form, and

(b) is to prepare a nomination form for signature at the request of any member of the corporation,

but it is not necessary for a nomination to be on a form supplied by the returning officer and a nomination can, subject to rule 13, be in an electronic format.

10. Candidate's particulars

10.1 The nomination form must state the candidate's:

(a) full name,

(b) contact address in full (which should be a postal address although an e-mail address may also be provided for the purposes of electronic communication), and

(c) constituency or class within a constituency, of which the candidate is a member.

11. Declaration of interests

11.1 The nomination form must state:

(a) any financial interest that the candidate has in the corporation, and

(b) whether the candidate is a member of a political party, and if so, which party, and if

the candidate has no such interests, the paper must include a statement to that effect.

12. Declaration of eligibility

12.1 The nomination form must include a declaration made by the candidate:

(a) that he or she is not prevented from being a Governor by paragraph 8 of Schedule 7 of the 2006 Act or by any provision of the constitution; and,

(b) for a member of the public or patient constituency, of the particulars of his or her qualification to vote as a member of that constituency, or class within that constituency, for which the election is being held.

13. Signature of candidate

13.1 The nomination form must be signed and dated by the candidate, in a manner prescribed by the returning officer, indicating that:

(a) they wish to stand as a candidate,

(b) their declaration of interests as required under rule 11, is true and correct, and

(c) their declaration of eligibility, as required under rule 12, is true and correct.

13.2 Where the return of nomination forms in an electronic format is permitted, the returning officer shall specify the particular signature formalities (if any) that will need to be complied with by the candidate.

14. Decisions as to the validity of nomination

14.1 Where a nomination form is received by the returning officer in accordance with these rules, the candidate is deemed to stand for election unless and until the returning officer:

(a) decides that the candidate is not eligible to stand,

(b) decides that the nomination form is invalid,

(c) receives satisfactory proof that the candidate has died, or

(d) receives a written request by the candidate of their withdrawal from candidacy.

14.2 The returning officer is entitled to decide that a nomination form is invalid only on one of the following grounds:

(a) that the paper is not received on or before the final time and date for return of nomination forms, as specified in the notice of the election,

(b) that the paper does not contain the candidate's particulars, as required by rule 10;

(c) that the paper does not contain a declaration of the interests of the candidate, as required by rule 11,

(d) that the paper does not include a declaration of eligibility as required by rule 12, or

(e) that the paper is not signed and dated by the candidate, if required by rule 13.

14.3 The returning officer is to examine each nomination form as soon as is practicable after he or she has received it and decide whether the candidate has been validly nominated.

14.4 Where the returning officer decides that a nomination is invalid, the returning officer must endorse this on the nomination form, stating the reasons for their decision.

14.5 The returning officer is to send notice of the decision as to whether a nomination is valid or invalid to the candidate at the contact address given in the candidate's nomination form. If an e-mail address has been given in the candidate's nomination form (in addition to the candidate's postal address), the returning officer may send notice of the decision to that address.

15. Publication of statement of candidates

15.1 The returning officer is to prepare and publish a statement showing the candidates who are standing for election.

15.2 The statement must show:

(a) the name, contact address (which shall be the candidate's postal address), and constituency or class within a constituency of each candidate standing, and

(b) the declared interests of each candidate standing, as

given in their nomination form.

15.3 The statement must list the candidates standing for election in alphabetical order by surname.

15.4 The returning officer must send a copy of the statement of candidates and copies of the nomination forms to the corporation as soon as is practicable after publishing the statement.

16. Inspection of statement of nominated candidates and nomination forms

16.1 The corporation is to make the statement of the candidates and the nomination forms supplied by the returning officer under rule 15.4 available for inspection by members of the corporation free of charge at all reasonable times.

16.2 If a member of the corporation requests a copy or extract of the statement of candidates or their nomination forms, the corporation is to provide that member with the copy or extract free of charge.

17. Withdrawal of candidates

17.1 A candidate may withdraw from election on or before the date and time for withdrawal by candidates, by providing to the returning officer a written notice of withdrawal which is signed by the candidate and attested by a witness.

18. Method of election

18.1 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is greater than the number of members to be elected to the council of governors, a poll is to be taken in accordance with Parts 5 and 6 of these rules.

18.2 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is equal to the number of members to be elected to the council of governors, those candidates are to be declared elected in accordance with Part 7 of these rules.

18.3 If the number of candidates remaining validly nominated for an election after any withdrawals under these rules is less than the number of members to be elected to be council of governors, then:

(a) the candidates who remain validly nominated are to be declared elected in accordance with Part 7 of these rules, and

(b) the returning officer is to order a new election to fill any vacancy which remains unfilled, on a day appointed by him or her in consultation with the corporation.

PART 5: CONTESTED ELECTIONS

19. Poll to be taken by ballot

19.1 The votes at the poll must be given by secret ballot.

19.2 The votes are to be counted and the result of the poll determined in accordance with Part 6 of these rules.

19.3 The corporation may decide that voters within a constituency or class within a constituency, may, subject to rule 19.4, cast their votes at the poll using such different methods of polling in any combination as the corporation may determine.

19.4 The corporation may decide that voters within a constituency or class within a constituency for whom an e-mail address is included in the list of eligible voters may only cast their votes at the poll using an e-voting method of polling.

19.5 Before the corporation decides, in accordance with rule 19.3 that one or more e- voting methods of polling will be made available for the purposes of the poll, the corporation must satisfy itself that:

(a) if internet voting is to be a method of polling, the internet voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate internet voting record in respect of any voter who casts his or her vote using the internet voting system;

(b) if telephone voting to be a method of polling, the telephone voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate telephone voting record in respect of any voter who casts his or her vote using the telephone voting system;

(c) if text message voting is to be a method of polling, the text message voting system to be used for the purpose of the election is:

(i) configured in accordance with these rules; and

(ii) will create an accurate text voting record in respect of any voter who casts his or her vote using the text message voting system.

20. The ballot paper

20.1 The ballot of each voter (other than a voter who casts his or her ballot by an e- voting method of polling) is to consist of a ballot paper with the persons remaining validly nominated for an election after any withdrawals under these rules, and no others, inserted in the paper.

20.2 Every ballot paper must specify:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(d) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) instructions on how to vote by all available methods of polling, including the relevant voter's voter ID number if one or more e-voting methods of polling are available,

(f) if the ballot paper is to be returned by post, the address for its return and the date and time of the close of the poll, and

(g) the contact details of the returning officer.

20.3 Each ballot paper must have a unique identifier.

20.4 Each ballot paper must have features incorporated into it to prevent it from being reproduced.

21. The declaration of identity (public and patient constituencies)

21.1 The corporation shall require each voter who participates in an election for a public or patient constituency to make a declaration confirming:

(a) that the voter is the person:

(i) to whom the ballot paper was addressed, and/or

(ii) to whom the voter ID number contained within the e-voting information was allocated,

(b) that he or she has not marked or returned any other voting information in the election, and

(c) the particulars of his or her qualification to vote as a member of the constituency or class within the constituency for which the election is being held,
("declaration of identity")

and the corporation shall make such arrangements as it considers appropriate to facilitate the making and the return of a declaration of identity by each voter, whether by the completion of a paper form ("ID declaration form") or the use of an electronic method.

21.2 The voter must be required to return his or her declaration of identity with his or her ballot.

21.3 The voting information shall caution the voter that if the declaration of identity is not duly returned or is returned without having been made correctly, any vote cast by the voter may be declared invalid.

Action to be taken before the poll

22. List of eligible voters

22.1 The corporation is to provide the returning officer with a list of the members of the constituency or class within a constituency for which the election is being held who are eligible to vote by virtue of rule 27 as soon as is reasonably practicable after the final date for the delivery of notices of withdrawals by candidates from an election.

22.2 The list is to include, for each member:

(a) a postal address; and,

(b) the member's e-mail address, if this has been provided

to which his or her voting information may, subject to rule 22.3, be sent.

22.3 The corporation may decide that the e-voting information is to be sent only by e- mail to those members in the list of eligible voters for whom an e-mail address is included in that list.

23. Notice of poll

23.1 The returning officer is to publish a notice of the poll stating:

(a) the name of the corporation,

(b) the constituency, or class within a constituency, for which the election is being held,

(c) the number of members of the council of governors to be elected from that constituency, or class with that constituency,

(d) the names, contact addresses, and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(e) that the ballot papers for the election are to be issued and returned, if appropriate, by post,

(f) the methods of polling by which votes may be cast at the election by voters in a constituency or class within a constituency, as determined by the corporation in accordance with rule 19.3,

(g) the address for return of the ballot papers,

(h) the uniform resource locator (URL) where, if internet voting is a method of polling, the polling website is located;

(i) the telephone number where, if telephone voting is a method of polling, the telephone voting facility is located,

(j) the telephone number or telephone short code where, if text message voting is a method of polling, the text message voting facility is located,

(k) the date and time of the close of the poll,

(l) the address and final dates for applications for replacement voting information, and

(m) the contact details of the returning officer.

24. Issue of voting information by returning officer

24.1 Subject to rule 24.3, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by post to each member of the corporation named in the list of eligible voters:

(a) a ballot paper and ballot paper envelope,

(b) the ID declaration form (if required),

(c) information about each candidate standing for election, pursuant to rule 61 of these rules, and

(d) a covering envelope; ("postal voting information").

24.2 Subject to rules 24.3 and 24.4, as soon as is reasonably practicable on or after the publication of the notice of the poll, the returning officer is to send the following information by e-mail and/ or by post to each member of the corporation named in the list of eligible voters whom the corporation determines in accordance with rule 19.3 and/ or rule 19.4 may cast his or her vote by an e-voting method of polling:

(a) instructions on how to vote and how to make a declaration of identity (if required),

(b) the voter's voter ID number,

(c) information about each candidate standing for election, pursuant to rule 64 of these rules, or details of where this information is readily available on the internet or available in such other formats as the Returning Officer thinks appropriate, (d) contact details of the returning officer, ("e-voting information").

24.3 The corporation may determine that any member of the corporation shall:

(a) only be sent postal voting information; or

(b) only be sent e-voting information; or

(c) be sent both postal voting information and e-voting information;

for the purposes of the poll.

24.4 If the corporation determines, in accordance with rule 22.3, that the e-voting information is to be sent only by e-mail to those members in the list of eligible voters for whom an e-mail address is included in that list, then the returning officer shall only send that information by e-mail.

24.5 The voting information is to be sent to the postal address and/ or e-mail address for each member, as specified in the list of eligible voters.

25. Ballot paper envelope and covering envelope

25.1 The ballot paper envelope must have clear instructions to the voter printed on it, instructing the voter to seal the ballot paper inside the envelope once the ballot paper has been marked.

25.2 The covering envelope is to have:

(a) the address for return of the ballot paper printed on it, and

(b) pre-paid postage for return to that address.

25.3 There should be clear instructions, either printed on the covering envelope or elsewhere, instructing the voter to seal the following documents inside the covering envelope and return it to the returning officer –

(a) the completed ID declaration form if required, and

(b) the ballot paper envelope, with the ballot paper sealed inside it.

26. E-voting systems

26.1 If internet voting is a method of polling for the relevant election, then the returning officer must provide a website for the purpose of voting over the internet (in these rules referred to as "the polling website").

26.2 If telephone voting is a method of polling for the relevant election then the returning officer must provide an automated telephone system for the purpose of voting by the use of a touch-tone telephone (in these rules referred to as “the telephone voting facility”).

26.3 If text message voting is a method of polling for the relevant election, then the returning officer must provide an automated text messaging system for the purpose of voting by text message (in these rules referred to as “the text message voting facility”).

26.4 The returning officer shall ensure that the polling website and internet voting system provided will:

(a) require a voter to:

(i) enter his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) the names and other particulars of the candidates standing for election, with the details and order being the same as in the statement of nominated candidates,

(v) instructions on how to vote and how to make a declaration of identity,

(vi) the date and time of the close of the poll, and

(vii) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("internet voting record") that is stored in the internet voting system in respect of each vote cast by a voter using the internet that comprises of-

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote,

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this; and

(f) prevent any voter from voting after the close of poll.

26.5 The returning officer shall ensure that the telephone voting facility and telephone voting system provided will:

(a) require a voter to

(i) enter his or her voter ID number in order to be able to cast his or her vote; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

(b) specify:

(i) the name of the corporation,

(ii) the constituency, or class within a constituency, for which the election is being held,

(iii) the number of members of the council of governors to be elected from that constituency, or class within that constituency,

(iv) instructions on how to vote and how to make a declaration of identity,

(v) the date and time of the close of the poll, and

(vi) the contact details of the returning officer;

(c) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("telephone voting record") that is stored in the telephone voting system in respect of each vote cast by a voter using the telephone that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(iii) the candidate or candidates for whom the voter has voted; and

(iv) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

26.6 The returning officer shall ensure that the text message voting facility and text messaging voting system provided will:

(a) require a voter to:

(i) provide his or her voter ID number; and

(ii) where the election is for a public or patient constituency, make a declaration of identity;

in order to be able to cast his or her vote;

(b) prevent a voter from voting for more candidates than he or she is entitled to at the election;

(d) create a record ("text voting record") that is stored in the text messaging voting system in respect of each vote cast by a voter by text message that comprises of:

(i) the voter's voter ID number;

(ii) the voter's declaration of identity (where required);

(ii) the candidate or candidates for whom the voter has voted; and

(iii) the date and time of the voter's vote

(e) if the voter's vote has been duly cast and recorded, provide the voter with confirmation of this;

(f) prevent any voter from voting after the close of poll.

The poll

27. Eligibility to vote

27.1 An individual, who becomes a member of the corporation on or before the closing date for the receipt of nominations by candidates for the election, is eligible to vote in that election.

28. Voting by persons who require assistance

28.1 The returning officer is to put in place arrangements to enable requests for assistance to vote to be made.

28.2 Where the returning officer receives a request from a voter who requires assistance to vote, the returning officer is to make such arrangements as he or she considers necessary to enable that voter to vote.

29. Spoilt ballot papers and spoilt text message votes

29.1 If a voter has dealt with his or her ballot paper in such a manner that it cannot be accepted as a ballot paper (referred to as a "spoilt ballot paper"), that voter may apply to the returning officer for a replacement ballot paper.

29.2 On receiving an application, the returning officer is to obtain the details of the unique identifier on the spoilt ballot paper, if he or she can obtain it.

29.3 The returning officer may not issue a replacement ballot paper for a spoilt ballot paper unless he or she:

(a) is satisfied as to the voter's identity; and

(b) has ensured that the completed ID declaration form, if required, has not been returned.

29.4 After issuing a replacement ballot paper for a spoilt ballot paper, the returning officer shall enter in a list ("the list of spoilt ballot papers"):

(a) the name of the voter, and

(b) the details of the unique identifier of the spoilt ballot paper (if that officer was able to obtain it), and

(c) the details of the unique identifier of the replacement ballot paper.

29.5 If a voter has dealt with his or her text message vote in such a manner that it cannot be accepted as a vote (referred to as a "spoilt text message vote"), that voter may apply to the returning officer for a replacement voter ID number.

29.6 On receiving an application, the returning officer is to obtain the details of the voter ID number on the spoilt text message vote, if he or she can obtain it.

29.7 The returning officer may not issue a replacement voter ID number in respect of a spoilt text message vote unless he or she is satisfied as to the voter's identity.

29.8 After issuing a replacement voter ID number in respect of a spoilt text message vote, the returning officer shall enter in a list ("the list of spoilt text message votes"):

(a) the name of the voter, and

(b) the details of the voter ID number on the spoilt text message vote (if that officer was able to obtain it), and

(c) the details of the replacement voter ID number issued to the voter.

30. Lost voting information

30.1 Where a voter has not received his or her voting information by the tenth day before the close of the poll, that voter may apply to the returning officer for replacement voting information.

30.2 The returning officer may not issue replacement voting information in respect of lost voting information unless he or she:

(a) is satisfied as to the voter's identity,

(b) has no reason to doubt that the voter did not receive the original voting information,

(c) has ensured that no declaration of identity, if required, has been returned.

30.3 After issuing replacement voting information in respect of lost voting information, the returning officer shall enter in a list ("the list of lost ballot documents"):

(a) the name of the voter

(b) the details of the unique identifier of the replacement ballot paper, if applicable, and

(c) the voter ID number of the voter.

31. Issue of replacement voting information

31.1 If a person applies for replacement voting information under rule 29 or 30 and a declaration of identity has already been received by the returning officer in the name of that voter, the returning officer may not issue replacement voting information unless, in addition to the requirements imposed by rule 29.3 or 30.2, he or she is also satisfied that that person has not already voted in the election, notwithstanding the fact that a declaration of identity if required has already been received by the returning officer in the name of that voter.

31.2 After issuing replacement voting information under this rule, the returning officer shall enter in a list ("the list of tendered voting information"):

(a) the name of the voter,

(b) the unique identifier of any replacement ballot paper issued under this rule;

(c) the voter ID number of the voter.

32. ID declaration form for replacement ballot papers (public and patient constituencies)

32.1 In respect of an election for a public or patient constituency an ID declaration form must be issued with each replacement ballot paper requiring the voter to make a declaration of identity.

Polling by internet, telephone or text

33. Procedure for remote voting by internet

33.1 To cast his or her vote using the internet, a voter will need to gain access to the polling website by keying in the URL of the polling website provided in the voting information.

33.2 When prompted to do so, the voter will need to enter his or her voter ID number.

33.3 If the internet voting system authenticates the voter ID number, the system will give the voter access to the polling website for the election in which the voter is eligible to vote.

33.4 To cast his or her vote, the voter will need to key in a mark on the screen opposite the particulars of the candidate or candidates for whom he or she wishes to cast his or her vote.

33.5 The voter will not be able to access the internet voting system for an election once his or her vote at that election has been cast.

34. Voting procedure for remote voting by telephone

34.1 To cast his or her vote by telephone, the voter will need to gain access to the telephone voting facility by calling the designated telephone number provided in the voter information using a telephone with a touch-tone keypad.

34.2 When prompted to do so, the voter will need to enter his or her voter ID number using the keypad.

34.3 If the telephone voting facility authenticates the voter ID number, the voter will be prompted to vote in the election.

34.4 When prompted to do so the voter may then cast his or her vote by keying in the numerical voting code of the candidate or candidates, for whom he or she wishes to vote.

34.5 The voter will not be able to access the telephone voting facility for an election once his or her vote at that election has been cast.

35. Voting procedure for remote voting by text message

35.1 To cast his or her vote by text message the voter will need to gain access to the text message voting facility by sending a text message to the designated telephone number or telephone short code provided in the voter information.

35.2 The text message sent by the voter must contain his or her voter ID number and the numerical voting code for the candidate or candidates, for whom he or she wishes to vote.

35.3 The text message sent by the voter will need to be structured in accordance with the instructions on how to vote contained in the voter information, otherwise the vote will not be cast.

Procedure for receipt of envelopes, internet votes, telephone votes and text message votes

36. Receipt of voting documents

36.1 Where the returning officer receives:

(a) a covering envelope, or

(b) any other envelope containing an ID declaration form if required, a ballot paper envelope, or a ballot paper,

before the close of the poll, that officer is to open it as soon as is practicable; and rules 37 and 38 are to apply.

36.2 The returning officer may open any covering envelope or any ballot paper envelope for the purposes of rules 37 and 38, but must make arrangements to ensure that no person obtains or communicates information as to:

(a) the candidate for whom a voter has voted, or

(b) the unique identifier on a ballot paper.

36.3 The returning officer must make arrangements to ensure the safety and security of the ballot papers and other documents.

37. Validity of votes

37.1 A ballot paper shall not be taken to be duly returned unless the returning officer is satisfied that it has been received by the returning officer before the close of the poll, with an ID declaration form if required that has been correctly completed, signed and dated.

37.2 Where the returning officer is satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) put the ID declaration form if required in a separate packet, and

(b) put the ballot paper aside for counting after the close of the poll.

37.3 Where the returning officer is not satisfied that rule 37.1 has been fulfilled, he or she is to:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier on the ballot paper in a list of disqualified documents (the "list of disqualified documents"); and

(d) place the document or documents in a separate packet.

37.4 An internet, telephone or text message vote shall not be taken to be duly returned unless the returning officer is satisfied that the internet voting record, telephone voting record or text voting record (as applicable) has been received by the returning officer before the close of the poll, with a declaration of identity if required that has been correctly made.

37.5 Where the returning officer is satisfied that rule 37.4 has been fulfilled, he or she is to put the internet voting record, telephone voting record or text voting record (as applicable) aside for counting after the close of the poll.

37.6 Where the returning officer is not satisfied that rule 37.4 has been fulfilled, he or she is to:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents; and

(c) place the document or documents in a separate packet.

38. Declaration of identity but no ballot paper (public and patient constituency)[1]

38.1 Where the returning officer receives an ID declaration form if required but no ballot paper, the returning officer is to:

(a) mark the ID declaration form "disqualified",

(b) record the name of the voter in the list of disqualified documents, indicating that a declaration of identity was received from the voter without a ballot paper, and

(c) place the ID declaration form in a separate packet.

39. De-duplication of votes

39.1 Where different methods of polling are being used in an election, the returning officer shall examine all votes cast to ascertain if a voter ID number has been used more than once to cast a vote in the election.

39.2 If the returning officer ascertains that a voter ID number has been used more than once to cast a vote in the election he or she shall:

(a) only accept as duly returned the first vote received that was cast using the relevant voter ID number; and

(b) mark as "disqualified" all other votes that were cast using the relevant voter ID number

39.3 Where a ballot paper is disqualified under this rule the returning officer shall:

(a) mark the ballot paper "disqualified",

(b) if there is an ID declaration form accompanying the ballot paper, mark it "disqualified" and attach it to the ballot paper,

(c) record the unique identifier and the voter ID number on the ballot paper in the list of disqualified documents;

(d) place the document or documents in a separate packet; and

(e) disregard the ballot paper when counting the votes in accordance with these rules.

39.4 Where an internet voting record, telephone voting record or text voting record is disqualified under this rule the returning officer shall:

(a) mark the internet voting record, telephone voting record or text voting record (as applicable) "disqualified",

[1] It should not be possible, technically, to make a declaration of identity electronically without also submitting a vote.

(b) record the voter ID number on the internet voting record, telephone voting record or text voting record (as applicable) in the list of disqualified documents;

(c) place the internet voting record, telephone voting record or text voting record (as applicable) in a separate packet, and

(d) disregard the internet voting record, telephone voting record or text voting record (as applicable) when counting the votes in accordance with these rules.

40. Sealing of packets

40.1 As soon as is possible after the close of the poll and after the completion of the procedure under rules 37 and 38, the returning officer is to seal the packets containing:

(a) the disqualified documents, together with the list of disqualified documents inside it,

(b) the ID declaration forms, if required,

(c) the list of spoilt ballot papers and the list of spoilt text message votes,

(d) the list of lost ballot documents,

(e) the list of eligible voters, and

(f) the list of tendered voting information

and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

PART 6: COUNTING THE VOTES

STV41. Interpretation of Part 6

STV41.1 In Part 6 of these rules:

"*ballot document*" means a ballot paper, internet voting record, telephone voting record or text voting record.

"*continuing candidate*" means any candidate not deemed to be elected, and not excluded,

"*count*" means all the operations involved in counting of the first preferences recorded for candidates, the transfer of the surpluses of elected candidates, and the transfer of the votes of the excluded candidates,

"*deemed to be elected*" means deemed to be elected for the purposes of counting of votes but without prejudice to the declaration of the result of the poll,

"*mark*" means a figure, an identifiable written word, or a mark such as "X", "*non-*

transferable vote" means a ballot document:

(a) on which no second or subsequent preference is recorded for a continuing candidate,

or

(b) which is excluded by the returning officer under rule STV49,

"*preference*" as used in the following contexts has the meaning assigned below:

(a) "first preference" means the figure "1" or any mark or word which clearly indicates a first (or only) preference,

(b) "next available preference" means a preference which is the second, or as the case may be, subsequent preference recorded in consecutive order for a continuing candidate (any candidate who is deemed to be elected or is excluded thereby being ignored); and

(c) in this context, a "second preference" is shown by the figure "2" or any mark or word which clearly indicates a second preference, and a third preference by the figure "3" or any mark or word which clearly indicates a third preference, and so on,

"*quota*" means the number calculated in accordance with rule STV46,

"*surplus*" means the number of votes by which the total number of votes for any candidate (whether first preference or transferred votes, or a combination of both) exceeds the quota; but references in these rules to the transfer of the surplus means the transfer (at a transfer value) of all transferable ballot documents from the candidate who has the surplus,

"*stage of the count*" means:

(a) the determination of the first preference vote of each candidate,
(b) the transfer of a surplus of a candidate deemed to be elected, or
(c) the exclusion of one or more candidates at any given time,

"*transferable vote*" means a ballot document on which, following a first preference, a second or subsequent preference is recorded in consecutive numerical order for a continuing candidate,

"*transferred vote*" means a vote derived from a ballot document on which a second or subsequent preference is recorded for the candidate to whom that ballot document has been transferred, and

"*transfer value*" means the value of a transferred vote calculated in accordance with rules STV47.4 or STV47.7.

42. Arrangements for counting of the votes

42.1 The returning officer is to make arrangements for counting the votes as soon as is practicable after the close of the poll.

42.2 The returning officer may make arrangements for any votes to be counted using vote counting software where:

(a) the board of directors and the council of governors of the corporation have approved:
  (i) the use of such software for the purpose of counting votes in the relevant election, and
  (ii) a policy governing the use of such software, and
(b) the corporation and the returning officer are satisfied that the use of such software will produce an accurate result.

43. The count

43.1 The returning officer is to:

(a) count and record the number of:
  (iii) ballot papers that have been returned; and
  (iv) the number of internet voting records, telephone voting records and/or text voting records that have been created, and
(b) count the votes according to the provisions in this Part of the rules and/or the provisions of any policy approved pursuant to rule 42.2(ii) where vote counting software is being used.

43.2 The returning officer, while counting and recording the number of ballot papers, internet voting records, telephone voting records and/or text voting records and counting the votes, must make arrangements to ensure that no person obtains or communicates information as to the unique identifier on a ballot paper or the voter

ID number on an internet voting record, telephone voting record or text voting record.

43.3 The returning officer is to proceed continuously with counting the votes as far as is practicable.

STV44. Rejected ballot papers and rejected text voting records

STV44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the ballot paper shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.2 The returning officer is to endorse the word "rejected" on any ballot paper which under this rule is not to be counted.

STV44.3 Any text voting record:

(a) on which the figure "1" standing alone is not placed so as to indicate a first preference for any candidate,

(b) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(c) which is unmarked or rejected because of uncertainty,

shall be rejected and not counted, but the text voting record shall not be rejected by reason only of carrying the words "one", "two", "three" and so on, or any other mark instead of a figure if, in the opinion of the returning officer, the word or mark clearly indicates a preference or preferences.

STV44.4 The returning officer is to endorse the word "rejected" on any text voting record which under this rule is not to be counted.

STV44.5 The returning officer is to draw up a statement showing the number of ballot papers rejected by him or her under each of the subparagraphs (a) to (d) of rule STV44.1 and the number of text voting records rejected by him or her under each of the sub- paragraphs (a) to (c) of rule STV44.3.

FPP44. Rejected ballot papers and rejected text voting records

FPP44.1 Any ballot paper:

(a) which does not bear the features that have been incorporated into the other ballot papers to prevent them from being reproduced,

(b) on which votes are given for more candidates than the voter is entitled to vote,

(c) on which anything is written or marked by which the voter can be identified except the unique identifier, or

(d) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.2 and FPP44.3, be rejected and not counted.

FPP44.2 Where the voter is entitled to vote for more than one candidate, a ballot paper is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.3 A ballot paper on which a vote is marked:

(a) elsewhere than in the proper place,

(b) otherwise than by means of a clear mark,

(c) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the paper is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.4 The returning officer is to:

(a) endorse the word “rejected” on any ballot paper which under this rule is not to be counted, and

(b) in the case of a ballot paper on which any vote is counted under rules FPP44.2 and FPP 44.3, endorse the words “rejected in part” on the ballot paper and indicate which vote or votes have been counted.

FPP44.5 The returning officer is to draw up a statement showing the number of rejected ballot papers under the following headings:

(a) does not bear proper features that have been incorporated into the ballot paper,

(b) voting for more candidates than the voter is entitled to,

(c) writing or mark by which voter could be identified, and

(d) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of ballot papers

rejected in part.

FPP44.6 Any text voting record:

(a) on which votes are given for more candidates than the voter is entitled to vote,

(b) on which anything is written or marked by which the voter can be identified except the voter ID number, or

(c) which is unmarked or rejected because of uncertainty,

shall, subject to rules FPP44.7 and FPP44.8, be rejected and not counted.

FPP44.7 Where the voter is entitled to vote for more than one candidate, a text voting record is not to be rejected because of uncertainty in respect of any vote where no uncertainty arises, and that vote is to be counted.

FPP44.8 A text voting record on which a vote is marked:

(a) otherwise than by means of a clear mark,

(b) by more than one mark,

is not to be rejected for such reason (either wholly or in respect of that vote) if an intention that the vote shall be for one or other of the candidates clearly appears, and the way the text voting record is marked does not itself identify the voter and it is not shown that he or she can be identified by it.

FPP44.9 The returning officer is to:

(a) endorse the word "rejected" on any text voting record which under this rule is not to be counted, and

(b) in the case of a text voting record on which any vote is counted under rules FPP44.7 and FPP 44.8, endorse the words "rejected in part" on the text voting record and indicate which vote or votes have been counted.

FPP44.10 The returning officer is to draw up a statement showing the number of rejected text voting records under the following headings:

(a) voting for more candidates than the voter is entitled to,

(b) writing or mark by which voter could be identified, and

(c) unmarked or rejected because of uncertainty,

and, where applicable, each heading must record the number of text voting records rejected in part.

STV45. First stage

STV45.1 The returning officer is to sort the ballot documents into parcels according to the candidates for whom the first preference votes are given.

STV45.2 The returning officer is to then count the number of first preference votes given on ballot documents for each candidate and is to record those numbers.

STV45.3 The returning officer is to also ascertain and record the number of valid ballot documents.

STV46. The quota

STV46.1 The returning officer is to divide the number of valid ballot documents by a number exceeding by one the number of members to be elected.

STV46.2 The result, increased by one, of the division under rule STV46.1 (any fraction being disregarded) shall be the number of votes sufficient to secure the election of a candidate (in these rules referred to as "the quota").

STV46.3 At any stage of the count a candidate whose total votes equals or exceeds the quota shall be deemed to be elected, except that any election where there is only one vacancy a candidate shall not be deemed to be elected until the procedure set out in rules STV47.1 to STV47.3 has been complied with.

STV47. Transfer of votes

STV47.1 Where the number of first preference votes for any candidate exceeds the quota, the returning officer is to sort all the ballot documents on which first preference votes are given for that candidate into sub- parcels so that they are grouped:

(a) according to next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.2 The returning officer is to count the number of ballot documents in each parcel referred to in rule STV47.1.

STV47.3 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.1(a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.4 The vote on each ballot document transferred under rule STV47.3 shall be at a value ("the transfer value") which:

(a) reduces the value of each vote transferred so that the total value of all such votes does not exceed the surplus, and

(b) is calculated by dividing the surplus of the candidate from whom the votes are being transferred by the total number of the ballot documents on which those votes are given, the calculation being made to two decimal places (ignoring the remainder if any).

STV47.5 Where at the end of any stage of the count involving the transfer of ballot documents, the number of votes for any candidate exceeds the quota, the returning officer is to sort the ballot documents in the sub-parcel of transferred votes which was last received by that candidate into separate sub-parcels so that they are grouped:

(a) according to the next available preference given on those ballot documents for any continuing candidate, or

(b) where no such preference is given, as the sub-parcel of non-transferable votes.

STV47.6 The returning officer is, in accordance with this rule and rule STV48, to transfer each sub-parcel of ballot documents referred to in rule STV47.5 (a) to the candidate for whom the next available preference is given on those ballot documents.

STV47.7 The vote on each ballot document transferred under rule STV47.6 shall be at:

(a) a transfer value calculated as set out in rule STV47.4(b), or

(b) at the value at which that vote was received by the candidate from whom it is now being transferred,

whichever is the less.

STV47.8 Each transfer of a surplus constitutes a stage in the count.

STV47.9 Subject to rule STV47.10, the returning officer shall proceed to transfer transferable ballot documents until no candidate who is deemed to be elected has a surplus or all the vacancies have been filled.

STV47.10 Transferable ballot documents shall not be liable to be transferred where any surplus or surpluses which, at a particular stage of the count, have not already been transferred, are:

(a) less than the difference between the total vote then credited to the continuing candidate with the lowest recorded vote and the vote of the candidate with the next lowest recorded vote, or

(b) less than the difference between the total votes of the two or more continuing candidates, credited at that stage of the count with the lowest recorded total numbers of votes and the candidate next above such candidates.

STV47.11 This rule does not apply at an election where there is only one vacancy.

STV48. Supplementary provisions on transfer

STV48.1 If, at any stage of the count, two or more candidates have surpluses, the transferable ballot documents of the candidate with the highest surplus shall be transferred first, and if:

(a) The surpluses determined in respect of two or more candidates are equal, the transferable ballot documents of the candidate who had the highest recorded vote at the earliest preceding stage at which they had unequal votes shall be transferred first, and

(b) the votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between those candidates by lot, and the transferable ballot documents of the candidate on whom the lot falls shall be transferred first.

STV48.2 The returning officer shall, on each transfer of transferable ballot documents under rule STV47:

(a) record the total value of the votes transferred to each candidate,

(b) add that value to the previous total of votes recorded for each candidate and record the new total,

(c) record as non-transferable votes the difference between the surplus and the total transfer value of the transferred votes and add that difference to the previously recorded total of non-transferable votes, and

(d) compare:

(i) the total number of votes then recorded for all of the candidates, together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV48.3 All ballot documents transferred under rule STV47 or STV49 shall be clearly marked, either individually or as a sub-parcel, so as to indicate the transfer value recorded at that time to each vote on that ballot document or, as the case may be, all the ballot documents in that sub-parcel.

STV48.4 Where a ballot document is so marked that it is unclear to the returning officer at any stage of the count under rule STV47 or STV49 for which candidate the next preference is recorded, the returning officer shall treat any vote on that ballot document as a non-transferable vote; and votes on a ballot document shall be so treated where, for example, the names of two or more candidates (whether continuing candidates or not) are so marked that, in the opinion of the returning officer, the same order of preference is indicated or the numerical sequence is broken.

STV49. Exclusion of candidates

STV49.1 If:

(a) all transferable ballot documents which under the provisions of rule STV47 (including that rule as applied by rule STV49.11) and this rule are required to be transferred, have been transferred, and

(b) subject to rule STV50, one or more vacancies remain to be filled,

the returning officer shall exclude from the election at that stage the candidate with the then lowest vote (or, where rule STV49.12 applies, the candidates with the then lowest votes).

STV49.2 The returning officer shall sort all the ballot documents on which first preference votes are given for the candidate or candidates excluded under rule STV49.1 into two sub-parcels so that they are grouped as:

(a) ballot documents on which a next available preference is given, and

(b) ballot documents on which no such preference is given (thereby including ballot documents on which preferences are given only for candidates who are deemed to be elected or are excluded).

STV49.3 The returning officer shall, in accordance with this rule and rule STV48, transfer each sub-parcel of ballot documents referred to in rule STV49.2 to the candidate for whom the next available preference is given on those ballot documents.

STV49.4 The exclusion of a candidate, or of two or more candidates together, constitutes a further stage of the count.

STV49.5 If, subject to rule STV50, one or more vacancies still remain to be filled, the returning officer shall then sort the transferable ballot documents, if any, which had been transferred to any candidate excluded under rule STV49.1 into sub- parcels according to their transfer value.

STV49.6 The returning officer shall transfer those ballot documents in the sub-parcel of transferable ballot documents with the highest transfer value to the continuing candidates in accordance with the next available preferences given on those ballot documents (thereby passing over candidates who are deemed to be elected or are excluded).

STV49.7 The vote on each transferable ballot document transferred under rule STV49.6 shall be at the value at which that vote was received by the candidate excluded under rule STV49.1.

STV49.8 Any ballot documents on which no next available preferences have been expressed shall be set aside as non-transferable votes.

STV49.9 After the returning officer has completed the transfer of the ballot documents in the sub-parcel of ballot documents with the highest transfer value he or she shall proceed to transfer in the same way the sub-parcel of ballot documents with the next highest value and so on until he has dealt with each sub-parcel of a candidate excluded under rule STV49.1.

STV49.10 The returning officer shall after each stage of the count completed under this rule:

(a) record:

(i) the total value of votes, or

(ii) the total transfer value of votes transferred to each candidate,

(b) add that total to the previous total of votes recorded for each candidate and record the new total,

(c) record the value of non-transferable votes and add that value to the previous non-transferable votes total, and

(d) compare:

(i) the total number of votes then recorded for each candidate together with the total number of non-transferable votes, with

(ii) the recorded total of valid first preference votes.

STV49.11 If after a transfer of votes under any provision of this rule, a candidate has a surplus, that surplus shall be dealt with in accordance with rules STV47.5 to STV47.10 and rule STV48.

STV49.12 Where the total of the votes of the two or more lowest candidates, together with any surpluses not transferred, is less than the number of votes credited to the next lowest candidate, the returning officer shall in one operation exclude such two or more candidates.

STV49.13 If when a candidate has to be excluded under this rule, two or more candidates each have the same number of votes and are lowest:

(a) regard shall be had to the total number of votes credited to those candidates at the earliest stage of the count at which they had an unequal number of votes and the candidate with the lowest number of votes at that stage shall be excluded, and

(b) where the number of votes credited to those candidates was equal at all stages, the returning officer shall decide between the candidates by lot and the candidate on whom the lot falls shall be excluded.

STV50. Filling of last vacancies

STV50.1 Where the number of continuing candidates is equal to the number of vacancies remaining unfilled the continuing candidates shall thereupon be deemed to be elected.

STV50.2 Where only one vacancy remains unfilled and the votes of any one continuing candidate are equal to or greater than the total of votes credited to other continuing candidates together with any surplus not transferred, the candidate shall thereupon be deemed to be elected.

STV50.3 Where the last vacancies can be filled under this rule, no further transfer of votes shall be made.

STV51. Order of election of candidates

STV51.1 The order in which candidates whose votes equal or exceed the quota are deemed to be elected shall be the order in which their respective surpluses were transferred, or would have been transferred but for rule STV47.10.

STV51.2 A candidate credited with a number of votes equal to, and not greater than, the quota shall, for the purposes of this rule, be regarded as having had the smallest surplus at the stage of the count at which he obtained the quota.

STV51.3 Where the surpluses of two or more candidates are equal and are not required to be transferred, regard shall be had to the total number of votes credited to such candidates at the earliest stage of the count at which they had an unequal number of votes and the surplus of the candidate who had the greatest number of votes at that stage shall be deemed to be the largest.

STV51.4 Where the number of votes credited to two or more candidates were equal at all stages of the count, the returning officer shall decide between them by lot and the candidate on whom the lot falls shall be deemed to have been elected first.

FPP51. Equality of votes

FPP51.1 Where, after the counting of votes is completed, an equality of votes is found to exist between any candidates and the addition of a vote would entitle any of those candidates to be declared elected, the returning officer is to decide between those candidates by a lot, and proceed as if the candidate on whom the lot falls had received an additional vote.

PART 7: FINAL PROCEEDINGS IN CONTESTED AND UNCONTESTED ELECTIONS

FPP52. Declaration of result for contested elections

FPP52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidate or candidates whom more votes have been given than for the other candidates, up to the number of vacancies to be filled on the council of governors from the constituency, or class within a constituency, for which the election is being held to be elected,

(b) give notice of the name of each candidate who he or she has declared elected:

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation; and

(c) give public notice of the name of each candidate whom he or she has declared elected.

FPP52.2 The returning officer is to make:

(a) the total number of votes given for each candidate (whether elected or not), and

(b) the number of rejected ballot papers under each of the headings in rule FPP44.5,

(c) the number of rejected text voting records under each of the headings in rule FPP44.10,

available on request.

STV52. Declaration of result for contested elections

STV52.1 In a contested election, when the result of the poll has been ascertained, the returning officer is to:

(a) declare the candidates who are deemed to be elected under Part 6 of these rules as elected,

(b) give notice of the name of each candidate who he or she has declared elected –

(i) where the election is held under a proposed constitution pursuant to powers conferred on the [insert name] NHS Trust by section 33(4) of the 2006 Act, to the chairman of the NHS Trust, or

(ii) in any other case, to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

STV52.2 The returning officer is to make:

(a) the number of first preference votes for each candidate whether elected or not,

(b) any transfer of votes,

(c) the total number of votes for each candidate at each stage of the count at which such transfer took place,

(d) the order in which the successful candidates were elected, and

(e) the number of rejected ballot papers under each of the headings in rule STV44.1,

(f) the number of rejected text voting records under each of the headings in rule STV44.3,

available on request.

53. Declaration of result for uncontested elections

53.1 In an uncontested election, the returning officer is to as soon as is practicable after final day for the delivery of notices of withdrawals by candidates from the election:

(a) declare the candidate or candidates remaining validly nominated to be elected,

(b) give notice of the name of each candidate who he or she has declared elected to the chairman of the corporation, and

(c) give public notice of the name of each candidate who he or she has declared elected.

PART 8: DISPOSAL OF DOCUMENTS

54. Sealing up of documents relating to the poll

54.1 On completion of the counting at a contested election, the returning officer is to seal up the following documents in separate packets:

(a) the counted ballot papers, internet voting records, telephone voting records and text voting records,

(b) the ballot papers and text voting records endorsed with "rejected in part",

(c) the rejected ballot papers and text voting records, and

(d) the statement of rejected ballot papers and the statement of rejected text voting records, and ensure that complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

54.2 The returning officer must not open the sealed packets of:

(a) the disqualified documents, with the list of disqualified documents inside it,

(b) the list of spoilt ballot papers and the list of spoilt text message votes,

(c) the list of lost ballot documents, and

(d) the list of eligible voters,

or access the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage.

54.3 The returning officer must endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

55. Delivery of documents

55.1 Once the documents relating to the poll have been sealed up and endorsed pursuant to rule 56, the returning officer is to forward them to the chair of the corporation.

56. Forwarding of documents received after close of the poll

56.1 Where:

(a) any voting documents are received by the returning officer after the close of the poll, or

(b) any envelopes addressed to eligible voters are returned as undelivered too late to be resent, or

(c) any applications for replacement voting information are made too late to enable new voting information to be issued, the returning officer is to put them in a separate packet, seal it up, and endorse and forward it to the chairman of the corporation.

57. Retention and public inspection of documents

57.1 The corporation is to retain the documents relating to an election that are forwarded to the chairman by the returning officer under these rules for one year, and then, unless otherwise directed by the board of directors of the corporation, cause them to be destroyed.

57.2 With the exception of the documents listed in rule 58.1, the documents relating to an election that are held by the corporation shall be available for inspection by members of the public at all reasonable times.

57.3 A person may request a copy or extract from the documents relating to an election that are held by the corporation, and the corporation is to provide it, and may impose a reasonable charge for doing so.

58. Application for inspection of certain documents relating to an election

58.1 The corporation may not allow:

(a) the inspection of, or the opening of any sealed packet containing –

(i) any rejected ballot papers, including ballot papers rejected in part,

(ii) any rejected text voting records, including text voting records rejected in part,

(iii) any disqualified documents, or the list of disqualified documents,

(iv) any counted ballot papers, internet voting records, telephone voting records or text voting records, or

(v) the list of eligible voters, or

(b) access to or the inspection of the complete electronic copies of the internet voting records, telephone voting records and text voting records created in accordance with rule 26 and held in a device suitable for the purpose of storage, by any person without the consent of the board of directors of the corporation.

58.2 A person may apply to the board of directors of the corporation to inspect any of the documents listed in rule 58.1, and the board of directors of the corporation may only consent to such inspection if it is satisfied that it is necessary for the purpose of questioning an election pursuant to Part 11.

58.3 The board of directors of the corporation's consent may be on any terms or conditions that it thinks necessary, including conditions as to –

(a) persons,

(b) time,

(c) place and mode of inspection,

(d) production or opening,

and the corporation must only make the documents available for inspection in

accordance with those terms and conditions.

58.4 On an application to inspect any of the documents listed in rule 58.1 the board of directors of the corporation must:

(a) in giving its consent, and

(b) in making the documents available for inspection

ensure that the way in which the vote of any particular member has been given shall not be disclosed, until it has been established –

(i) that his or her vote was given, and

(ii) that Monitor has declared that the vote was invalid.

PART 9: DEATH OF A CANDIDATE DURING A CONTESTED ELECTION

FPP59. Countermand or abandonment of poll on death of candidate

FPP59.1 If at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) countermand notice of the poll, or, if voting information has been issued, direct that the poll be abandoned within that constituency or class, and

(b) order a new election, on a date to be appointed by him or her in consultation with the corporation, within the period of 40 days, computed in accordance with rule 3 of these rules, beginning with the day that the poll was countermanded or abandoned.

FPP59.2 Where a new election is ordered under rule FPP59.1, no fresh nomination is necessary for any candidate who was validly nominated for the election where the poll was countermanded or abandoned but further candidates shall be invited for that constituency or class.

FPP59.3 Where a poll is abandoned under rule FPP59.1(a), rules FPP59.4 to FPP59.7 are to apply.

FPP59.4 The returning officer shall not take any step or further step to open envelopes or deal with their contents in accordance with rules 38 and 39, and is to make up separate sealed packets in accordance with rule 40.

FPP59.5 The returning officer is to:

(a) count and record the number of ballot papers, internet voting records, telephone voting records and text voting records that have been received,

(b) seal up the ballot papers, internet voting records, telephone voting records and text voting records into packets, along with the records of the number of ballot papers, internet voting records, telephone voting records and text voting records and

ensure that complete electronic copies of the internet voting records telephone voting records and text voting records created in accordance with rule 26 are held in a device suitable for the purpose of storage.

FPP59.6 The returning officer is to endorse on each packet a description of:

(a) its contents,

(b) the date of the publication of notice of the election,

(c) the name of the corporation to which the election relates, and

(d) the constituency, or class within a constituency, to which the election relates.

FPP59.7 Once the documents relating to the poll have been sealed up and endorsed pursuant to rules FPP59.4 to FPP59.6, the returning officer is to deliver them to the chairman of the corporation, and rules 57 and 58 are to apply.

STV59. Countermand or abandonment of poll on death of candidate

STV59.1 If, at a contested election, proof is given to the returning officer's satisfaction before the result of the election is declared that one of the persons named or to be named as a candidate has died, then the returning officer is to:

(a) publish a notice stating that the candidate has died, and

(b) proceed with the counting of the votes as if that candidate had been excluded from the count so that –

(i) ballot documents which only have a first preference recorded for the candidate that has died, and no preferences for any other candidates, are not to be counted, and

(ii) ballot documents which have preferences recorded for other candidates are to be counted according to the consecutive order of those preferences, passing over preferences marked for the candidate who has died.

STV59.2 The ballot documents which have preferences recorded for the candidate who has died are to be sealed with the other counted ballot documents pursuant to rule 54.1(a).

PART 10: ELECTION EXPENSES AND PUBLICITY

Election expenses

60. Election expenses

60.1 Any expenses incurred, or payments made, for the purposes of an election which contravene this Part are an electoral irregularity, which may only be questioned in an application made to Monitor under Part 11 of these rules.

61. Expenses and payments by candidates

61.1 A candidate may not incur any expenses or make a payment (of whatever nature) for the purposes of an election, other than expenses or payments that relate to:

(a) personal expenses,

(b) travelling expenses, and expenses incurred while living away from home, and

(c) expenses for stationery, postage, telephone, internet (or any similar means of communication) and other petty expenses, to a limit of £100.

62. Election expenses incurred by other persons

62.1 No person may:

(a) incur any expenses or make a payment (of whatever nature) for the purposes of a candidate's election, whether on that candidate's behalf or otherwise, or

(b) give a candidate or his or her family any money or property (whether as a gift, donation, loan, or otherwise) to meet or contribute to expenses incurred by or on behalf of the candidate for the purposes of an election.

62.2 Nothing in this rule is to prevent the corporation from incurring such expenses, and making such payments, as it considers necessary pursuant to rules 63 and 64.

Publicity

63. Publicity about election by the corporation

63.1 The corporation may:

(a) compile and distribute such information about the candidates, and

(b) organise and hold such meetings to enable the candidates to speak and respond to questions, as it considers necessary.

63.2 Any information provided by the corporation about the candidates, including information compiled by the corporation under rule 64, must be:

(a) objective, balanced and fair,

(b) equivalent in size and content for all candidates,

(c) compiled and distributed in consultation with all of the candidates standing for election, and

(d) must not seek to promote or procure the election of a specific candidate or candidates, at the expense of the electoral prospects of one or more other candidates.

63.3 Where the corporation proposes to hold a meeting to enable the candidates to speak, the corporation must ensure that all of the candidates are invited to attend, and in organising and holding such a meeting, the corporation must not seek to promote or procure the election of a specific candidate or candidates at the expense of the electoral prospects of one or more other candidates.

64. Information about candidates for inclusion with voting information

64.1 The corporation must compile information about the candidates standing for election, to be distributed by the returning officer pursuant to rule 24 of these rules.

64.2 The information must consist of:

(a) a statement submitted by the candidate of no more than 250 words,

(b) if voting by telephone or text message is a method of polling for the election, the numerical voting code allocated by the returning officer to each candidate, for the purpose of recording votes using the telephone voting facility or the text message voting facility ("numerical voting code"), and

(c) a photograph of the candidate.

65. Meaning of "for the purposes of an election"

65.1 In this Part, the phrase "for the purposes of an election" means with a view to, or otherwise in connection with, promoting or procuring a candidate's election, including the prejudicing of another candidate's electoral prospects; and the phrase "for the purposes of a candidate's election" is to be construed accordingly.

65.2 The provision by any individual of his or her own services voluntarily, on his or her own time, and free of charge is not to be considered an expense for the purposes of this Part.

PART 11: QUESTIONING ELECTIONS AND THE CONSEQUENCE OF IRREGULARITIES

66. Application to question an election

66.1 An application alleging a breach of these rules, including an electoral irregularity under Part 10, may be made to Monitor.

66.2 An application may only be made once the outcome of the election has been declared by the returning officer.

66.3 An application may only be made to Monitor by:

(a) a person who voted at the election or who claimed to have had the right to vote, or

(b) a candidate, or a person claiming to have had a right to be elected at the election.

66.4 The application must:

(a) describe the alleged breach of the rules or electoral irregularity, and

(b) be in such a form as Monitor may require.

66.5 The application must be presented in writing within 21 days of the declaration of the result of the election.

66.6 If Monitor requests further information from the applicant, then that person must provide it as soon as is reasonably practicable.

66.7 Monitor shall delegate the determination of an application to a person or panel of persons to be nominated for the purpose.

66.8 The determination by the person or panel of persons nominated in accordance with rule 66.7 shall be binding on and shall be given effect by the corporation, the applicant and the members of the constituency (or class within a constituency) including all the candidates for the election to which the application relates.

66.9 Monitor may prescribe rules of procedure for the determination of an application including costs.

PART 12: MISCELLANEOUS

67. Secrecy

67.1 The following persons:

(a) the returning officer,

(b) the returning officer's staff,

must maintain and aid in maintaining the secrecy of the voting and the counting of the votes, and must not, except for some purpose authorised by law, communicate to any person any information as to:

(i) the name of any member of the corporation who has or has not been given voting information or who has or has not voted,

(ii) the unique identifier on any ballot paper,

(iii) the voter ID number allocated to any voter,

(iv) the candidate(s) for whom any member has voted.

67.2 No person may obtain or attempt to obtain information as to the candidate(s) for whom a voter is about to vote or has voted, or communicate such information to any person at any time, including the unique identifier on a ballot paper given to a voter or the voter ID number allocated to a voter.

67.3 The returning officer is to make such arrangements as he or she thinks fit to ensure that the individuals who are affected by this provision are aware of the duties it imposes.

68. Prohibition of disclosure of vote

68.1 No person who has voted at an election shall, in any legal or other proceedings to question the election, be required to state for whom he or she has voted.

69. Disqualification

69.1 A person may not be appointed as a returning officer, or as staff of the returning officer pursuant to these rules, if that person is:

(a) a member of the corporation,

(b) an employee of the corporation,

(c) a director of the corporation, or

(d) employed by or on behalf of a person who has been nominated for election.

70. Delay in postal service through industrial action or unforeseen event

70.1 If industrial action, or some other unforeseen event, results in a delay in:

(a) the delivery of the documents in rule 24, or

(b) the return of the ballot papers,

the returning officer may extend the time between the publication of the notice of the poll and the close of the poll by such period as he or she considers appropriate.